

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                   |  |   |  |   |  |  |  |  |  |
|---|--|-----------------------------------|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                   |  |   |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>DOA</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  |                                   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>D.C.</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u><br>d. STREET ADDRESS <u>4217 Van Ness</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Robert Ross Neal</u><br>First Middle Last   |  |                                   |  |   |  | 4. DATE OF DEATH <u>Dec. 8</u> 19 <u>67</u><br>Month Day Year   |  |  |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>White</u>     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Oct. 9 - 1910</u>   |  | 9. AGE (In years lost birthday) <u>57</u> yrs.     |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>   |  |                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. AIR</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>John Ross Neal</u>   |  |                                   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Florence Simpson</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>U.S. Navy</u>  |  |                                   |  | 16. SOCIAL SECURITY NO. <u>351-03-3121</u>  |  | 17. INFORMANT <u>Marion Neal</u> Address <u>Same as above</u>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced severe coronary arteriosclerosis</u> DUE TO<br>(c) <u>years</u> |  |                                   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                   |  |   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                                   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)               |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19 Apr, 1959</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1 Dec</u> 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above.   |  |                                   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>Herbert Martin Jr</u> M.D.  |  |                                   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED <u>9 Dec 67</u>                   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTIN JR</u>   |  |                                   |  |   |  | 22d. ADDRESS <u>4740 Cherry Chase Dr Ch. Ch. Md</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>  |  | 23b. DATE THEREOF <u>12/12/67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u> ADDRESS <u>5130 Wisconsin Ave. N.W.</u>   |  |                                   |  |   |  | 25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>MONT</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |   | c. LENGTH OF STAY IN TB<br><b>45 days</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |   | d. STREET ADDRESS<br><b>4216 Anthony Street</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>Y.</b> Last <b>NEWHOUSE</b>   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>21</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cauc</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 30, 1921</b>                                      |
| 9. AGE (In years last birthday)<br><b>46</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>15</b> Days <b>1</b> Hours <b>1</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Navy</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Romney, West Virginia</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>USA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Robert Newhouse</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Zona Shank</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1942-1962</b>  |   | 16. SOCIAL SECURITY NO.<br><b>232 26 0598</b>   |   |
| 17. INFORMANT<br><b>Mrs. Margaret B. Newhouse</b>  |   | Address <b>Kensington, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the urinary bladder</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>1810</b><br>(c) <b>1810</b><br>DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Nov. 7</b> , 19 <b>67</b> , to <b>Dec. 21</b> , 19 <b>67</b> that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 21</b> , 19 <b>67</b> , and that death occurred at <b>0655</b> M, from causes and on the date stated above.                     |   |   |   |
| 22a. SIGNATURE<br><b>Lawrence A. Jones</b> M.D.  |   | 22b. DATE SIGNED<br><b>Dec. 21, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence A. Jones, M. D.</b>  |   | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/24/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Indian Mound Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Romney, West Virginia</b> |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home</b><br><b>1331 Rockville Pike, Rockville, Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 28 1967</b>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |   |

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UNITED STATES OF AMERICA

Washington

Washington

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## CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>                  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b <u>7 days</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belmont</u> <u>15-1</u>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  |  |  | d. STREET ADDRESS <u>Rt # 2 Box 49</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <u>WILFRED Donald NICHOLSON</u>  |  |  |  | 4. DATE OF DEATH <u>Dec 26 1967</u>  |  |  |   |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2/15/18</u> <u>49</u> yrs.   |   |
| 9. AGE (In years last birthday) <u>49</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal Caretaker</u>                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>N 14</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Comas Md</u>                            |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  | 13. FATHER'S NAME <u>George E. Nicholson</u>   |  |  |   |
| 14. MOTHER'S MAIDEN NAME <u>Mary C. Whipp</u>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |  |  |   |
| 16. SOCIAL SECURITY NO. <u>214-30-8285</u>   |  |  |  | 17. INFORMANT <u>10413 Montrose Ave Donald Nicholson Son - Beth. Md.</u>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u><br>5810 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypokalemia</u> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 52</u> to <u>Dec 26 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 26 1967</u> , and that death occurred at <u>8:30</u> M, from causes on and on the date stated above.  |  |  |  |  |  |  |   |
| 22a. SIGNATURE <u>John G. Fawcett</u> M.D.   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <u>Dec 27, 1967</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) _____   |  |  |  | 22d. ADDRESS _____   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12/29/67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>Bethesda Montg - Md</u>                       |   |
| 24. FUNERAL DIRECTOR <u>William B. Hillman</u> ADDRESS <u>Barnesville, Md</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 2 1968</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |

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U.S. DEPARTMENT OF  
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BUREAU OF  
ECONOMIC ANALYSIS  
WASHINGTON, D.C.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

17321

**CERTIFICATE OF DEATH**

17320

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 ETHELSDA</u><br>c. LENGTH OF STAY IN 1b <u>14 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POOLIESVILLE</u><br>d. STREET ADDRESS _____<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>CHARLES</u> Middle <u>W.</u> Last <u>NORRIS</u>   |  |  | <b>4. DATE OF DEATH</b><br>Month <u>DEC</u> Day <u>20</u> Year <u>1967</u>   |   |  |  |  |
| <b>5. SEX</b><br><u>MALE</u>   | <b>6. COLOR OR RACE</b><br><u>WHITE</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>2/15/08</u>  | <b>9. AGE</b> (In years lost birthday) <u>59</u> yrs.   | IF UNDER 1 YEAR<br>Months _____ Days _____   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during usual of working life, even if retired)<br><u>OWNER - NORRIS LUMBER &amp; FUEL</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>MARYLAND</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>U.S.A</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>CHARLES NORRIS</u>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>CORA BAUMAN</u>  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>577-09-1672</u>   |  | <b>17. INFORMANT</b><br><u>VERA - WIFE - SAME</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis with thrombosis</u><br>DUE TO<br>(c) _____ |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH _____   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |  |  |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>19</u> o.m. p.m.  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____  | <b>20f. (City or town)</b> _____   | <b>(County)</b> _____   | <b>(State)</b> _____   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1965</u> <b>to</b> <u>12/20/1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/20/1967</u> , <b>and that death occurred at</b> <u>9:01 PM</u> , <b>from causes and on the date stated above.</b>  |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Robert Maccon</u> M.D.   |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |   | <b>22b. DATE SIGNED</b><br><u>12/20/67</u>   |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) _____  |  |  | <b>22d. ADDRESS</b><br><u>809 Viers Mill Rd, Rockville, Md</u>   |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>12/22/67</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Monocacy</u>  |  |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>William C. Hiltner, Barnesville, Md.</u>   |  | <b>23d. LOCATION</b> (City or Town) _____ (County) _____ (State) _____<br><u>Beallsville Montg. Md</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>DEC 21 1967</u>   |  |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>  |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery County</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery County</u>     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>  |  | d. STREET ADDRESS <u>121 Bradford Rd.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Nwell</u> Middle Last   |  | 4. DATE OF DEATH <u>December 12/13</u> Day <u>12</u> Month <u>13</u> Year <u>1967</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 10 1870</u> 97 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 13. FATHER'S NAME <u>Isaac A. Beckett</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Susan Milan</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>219-55-7732</u>   |  |
| 17. INFORMANT <u>Brooks E. Soderstrom</u>  |  | 18. ADDRESS <u>9059 Sligo Creek Pkwy Silver Spring, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarct</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u><br><u>Years</u>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old age (97)</u>  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>12/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>67</u> , and that death occurred at <u>10:40</u> A.M. from causes and on the date stated above.                                       |  |  |  |
| 22a. SIGNATURE <u>Richard Delaney</u>  |  | 22b. DATE SIGNED <u>12/14/1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Richard Delaney</u>  |  | 22d. ADDRESS <u>4323 Harvard St. Silver Spring, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Dec. 18, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Kansas City, Missouri</u>                     |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |

13329

UNITED STATES OF AMERICA

22

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17328

17322

|  |                                  |   |  |   |   |  |                               |
|--|----------------------------------|---|--|---|---|--|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓ |   |  |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |                                  |   | c. LENGTH OF STAY IN 1b<br><u>3 days</u> |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville</u> <u>16.2</u> |                               |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium &amp; Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>7401 New Hampshire Ave</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |                               |
| 3. NAME OF DECEASED (Type or print)<br>First <u>George</u> Middle <u>Edward</u> Last <u>Noyes</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>16</u> Year <u>1967</u>  |   |  |                               |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-7-93</u>        |   | 9. AGE (In years last birthday)<br><u>74</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Std. Oil Corp.</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                               |
| 13. FATHER'S NAME<br><u>Clarence Noyes</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Isabel Duguid</u>  |   |  |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>unknown</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>578-05-9877</u>   |  | 17. INFORMANT<br><u>Chart</u> Address   |   |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adams Stokes ATTACKER</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO<br>(c) <u>Arteriosclerosis obliterans</u> |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>hours</u><br><u>years</u>                                 |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Diabetes mellitus</u>   |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat While <input type="checkbox"/> of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>67</u> , to <u>12/16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>67</u> , and that death occurred at <u>11:25</u> A.M., from causes and on the date stated above.  |                                  |   |  |   |   |  |                               |
| 22a. SIGNATURE<br><u>Kenneth Crigg</u> M.D.  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |   | 22b. DATE SIGNED<br><u>12/16/67</u>  |                               |
| 22c. PHYSICIAN'S NAME (Type)   |                                  |   |  | 22d. ADDRESS  |   |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>12-20-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince George, Md.</u>   |                               |
| 24. FUNERAL DIRECTOR<br><u>Lea Funeral Home</u>  |                                  |   |  | ADDRESS<br><u>Washington, D.C.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 21 1967</u>  |                               |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13338

13338

OFFICE OF THE SECRETARY OF THE ARMY

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                              |   |                                   |
|---|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>MONTGOMERY</b>   |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>14 DAYS</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>   |                              | d. STREET ADDRESS<br><b>1602 CAREY LANE</b>   |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AGNES</b> Middle <b>(NMN)</b> Last <b>O'CONNOR</b>  |                              | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>25</b> Year <b>1967</b>  |                                   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1-6-02</b> |
| 9. AGE (In years last birthday) yrs.<br><b>65</b>   |                              | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WASH. DC.</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                   |
| 13. FATHER'S NAME<br><b>FRANK B MARTIN</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>GRACE McCHESNEY</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>218-54-7655</b>   |                                   |
| 17. INFORMANT<br><b>Martin O'Connor</b> Address<br><b>461 H St. NW, Wash., D.C.</b>   |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest during Surgery</b><br>DUE TO <b>4200</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>associated with Arteriosclerotic</b><br>DUE TO <b>Heart Disease + Arrhythmias</b><br>(c) <b>Heart Disease + Arrhythmias</b> |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                              | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |                                   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b>   |                              | 22. DATE SIGNED<br><b>DEC. 26, 1967</b>   |                                   |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>Dec. 27, 1967</b>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>  |                                   |
| 24. FUNERAL DIRECTOR<br><b>John B. Thomas</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                              | 25c. REGISTRAR'S ADDRESS<br><b>Warner E. Humphrey, Inc., 8434 Ga. Ave., S.S., Md.</b>   |                                   |

11334

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MONTGOMERY

MONTGOMERY

TAKOMA PARK

14 DAYS

SILVER SPRING

WASHINGTON STATEMENT & HISTORY

1005 CAREY LANE

ADRES

(MM) O'Connor

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25

X

D F W

X 1-8-05

HOUSEWIFE

WASH DC

FRANK B MARTIN

GRACE McCHESNEY

1004 1005 1006

113

Garland County Maryland  
Washington State  
Frank B Martin  
Grace McChesney

X X X X X X X

Washington State  
Garland County Maryland  
Frank B Martin  
Grace McChesney  
1004 1005 1006

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If the delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

17325

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17324

|   |                               |  |  |   |   |   |   |
|---|-------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>                        |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda.</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>DOA.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Echo Heights.</u> <u>15.1</u>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban.</u>  |                               |  |  | d. STREET ADDRESS<br><u>5424 Mohican Rd.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Nelson</u> Last <u>Oliver</u>   |                               |  |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>9</u> Year <u>1967</u>  |   |   |   |
| 5. SEX<br><u>M.</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 8. DATE OF BIRTH<br><u>June 13, 1900</u> |   | 9. AGE (In years last birthday)<br><u>67</u> yrs. | 10. UNDER 1 YEAR<br>Months <u></u> Days <u></u>   | 11. UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Insurance Agent</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D. C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |   |
| 13. FATHER'S NAME<br><u>Joseph A. Oliver</u>  |                               |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna Kinsinger</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>578-44-5350</u>  |  | 17. INFORMANT<br><u>Wife</u><br><u>Linda P. Oliver</u>  |   | Address<br><u>Same as Item 2.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO <u>Smoke inhalation &amp; Carbon Monoxide Poisoning</u><br>(b) <u>Conflagration ( Fire in home)</u><br>DUE TO <u></u><br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>900.0</u>   |                               |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Cerebral arteriosclerosis</u>  |                               |  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>House caught fire while asleep.</u>   |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>12:45</u> a.m. <u>Dec. 9</u> 1967   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home.</u>  |   | 20f. (City or town) (County) (State)<br><u>Glen Echo Heights Montgomery Md</u>                    |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |  |   |   |   |   |
| ACTUAL SIGNATURE<br><u>John S. Ball</u>   |                               | EXAMINER'S NAME (Type)<br><u>JOHN G. BALL</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22. DATE SIGNED<br><u>12/9/67</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |                               | 23b. DATE THEREOF<br><u>12-13-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory Suitland Pr, Geo Md</u>   |   | 23d. LOCATION (City or town) (County) (State)<br><u></u>  |   |
| 24. FUNERAL DIRECTOR<br><u>Robert A Pumphrey</u>  |                               |  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 15 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

## References

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |                  |   |                                   |  |   |  |   |   |       |
|---|------------------|---|-----------------------------------|--|---|--|---|---|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                  |   |                                   |  |   |  |   |   |       |
| 17326   |                  |   |                                   |  | 17325   |  |   |   |       |
| 1. PLACE OF DEATH   |                  |   |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  |   |   |       |
| a. COUNTY   |                  | Montgomery  |                                   |  | a. STATE  |  | Maryland  |   |       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                  | Bethesda (Rural)  |                                   |  | b. COUNTY   |  | Montgomery  |   |       |
| c. LENGTH OF STAY in 1b   |                  | 33 days   |                                   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |  | Rockville   |   |       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                  |   |                                   |  | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM?  |   |       |
| Naval Hospital  |                  |   |                                   |  | 306 Reading Ave.  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |       |
| 3. NAME OF DECEASED   |                  |   |                                   |  | 4. DATE OF DEATH  |  |   |   |       |
| (Type or print)   |                  | First Middle Last   |                                   |  | Month   |  | Day   |   | Year  |
|   |                  | Herbert C. ORAM   |                                   |  | 12  |  | 14  |   | 19 67 |
| 5. SEX  | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH                  |  | 9. AGE (In years last birthday) yrs.  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.  |       |
| Male  | Cauc             | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 4 SEPT 1895                       |  | 72  | Months   | Days  | Hours   | Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  |   | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country)                                   |  | 12. CITIZEN OF WHAT COUNTRY?  |   |       |
| U.S. Navy   |                  |   | Military                          |  | Massachusetts   |  | USA   |   |       |
| 13. FATHER'S NAME   |                  |   |                                   |  | 14. MOTHER'S MAIDEN NAME  |  |   |   |       |
| Information not available   |                  |   |                                   |  | Information not available   |  |   |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)   |                  |   | 16. SOCIAL SECURITY NO.           |  | 17. INFORMANT   |  |   |   |       |
| Yes <input type="checkbox"/> Not known <input checked="" type="checkbox"/>  |                  |   | Not known                         |  | 306 Reading Ave. Address<br>Leona Oram Rockville, Md.                                 |  |   |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                  |   |                                   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH                                    |       |
| PART I. DEATH WAS CAUSED BY:  |                  |   |                                   |  |   |  |   |   |       |
| IMMEDIATE CAUSE (a) 490X BILATERAL CONFLUENT LOBULAR PNEUMONITIS  |                  |   |                                   |  |   |  |   |   |       |
| DUE TO (b)  |                  |   |                                   |  |   |  |   |   |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)  |                  |   |                                   |  |   |  |   |   |       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                  |   |                                   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?  |       |
|   |                  |   |                                   |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  |   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |  |   |   |       |
| 20c. TIME OF INJURY Month, Day, Year  |                  |   |                                   | 20d. INJURY OCCURRED   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)                                |       |
| Hour o.m. p.m. 19   |                  |   |                                   | While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work            |   |  |   |   |       |
| 21. I certify that (I) (this hospital) attended the deceased from 13 NOV 1967 to 14 DEC 1967, that (I) (we) last saw the deceased alive on 14 DEC 1967, and that death occurred at 7:00 P.M., from causes and on the date stated above. |                  |   |                                   |  |   |  |   |   |       |
| 22a. SIGNATURE  |                  |   |                                   |  |   | 22b. DATE SIGNED   |   |   |       |
| E. PERLIN, LCDR, MC, USN  |                  |   |                                   |  |   | 16 DECEMBER 67   |   |   |       |
| 22c. PHYSICIAN'S NAME (Type)  |                  |   |                                   |  |   | 22d. ADDRESS   |   |   |       |
| E. PERLIN, LCDR, MC, USN  |                  |   |                                   |  |   | NAVAL HOSPITAL, BETHESDA, MD.  |   |   |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 23b. DATE THEREOF   |                                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)                          |   |   |       |
| Burial  |                  | 12/19/67  |                                   | Parklawn Cemetery  |   | Rockville, Maryland  |   |   |       |
| 24. FUNERAL DIRECTOR  |                  |   |                                   |  |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |       |
| 1331 Montgomery Ave.<br>Tyson & Wheeler, Rockville, Maryland  |                  |   |                                   |  |   | DATE DEC 21 1967   |   | Charles Judge   |       |



CLEARED WITH DR. REAP, B.B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                                       |   |   |  |   |   |  |
|---|--|--|---------------------------------------|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                                       |   |   |  |   |   |  |
| CERTIFICATE OF DEATH  |  |  |                                       |   |   |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  |  |                                       |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TAKOMA PARK</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>                                      |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>WASHINGTON SAN. &amp; HOSP</b>   |  |  |                                       |   | d. STREET ADDRESS<br><b>8105 EASTERN AVE #314</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ARLEY</b> Middle <b>OSWALT</b> Last <b>OSWALT</b>   |  |  |                                       |   | 4. DATE OF DEATH<br>Month <b>12</b> - Day <b>26</b> Year <b>1967</b>  |  |   |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>                     |                                       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>7-1-86</b>                                      |   | 9. AGE (In years last birthday)<br><b>81</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |                                       | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MISSISSIPPI</b>   |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                 |   |  |
| 13. FATHER'S NAME<br><b>George Goff</b>   |  |  |                                       |   | 14. MOTHER'S MAIDEN NAME<br><b>SYBIL WHITE</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>213-54-6661</b>        |                                       | 17. INFORMANT<br><b>GRACE OSWALT - SAME</b> Address <b>8105 Eastern Ave., S.S. Md.</b>  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b><br><b>4201</b> DUE TO <b>Gen Arteriosclerosis Cornary Ennuff</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen Arteriosclerosis Cornary Ennuff</b><br>(c) <b>Gen Arteriosclerosis Cornary Ennuff</b> |  |  |                                       |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH.<br><b>17 yrs</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |                                       |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>  |  |  |                                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/6/67</b> , 19 <b>67</b> , to <b>12/26/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/21/67</b> , 19 <b>67</b> , and that death occurred at <b>12/26/67</b> , M, from causes and on the date stated above.  |  |  |                                       |   |   |  |   |   |  |
| 22a. SIGNATURE<br><b>H. J. Morse</b>  |  |  |                                       |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>12/26/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>H. J. Morse</b>  |  |  |                                       |   | 22d. ADDRESS<br><b>9030 Carroll Ave Takoma Park Md</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify).  |  | 23b. DATE THEREOF                                    |                                       | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION (City or Town) (County) (State)                               |   |  |
| <b>Trans-burial</b>   |  | <b>Dec. 30, 1967</b>                                 |                                       | <b>Lakewood Memorial Park</b>   |   |  | <b>Jackson, Mississippi</b>   |   |  |
| 25a. REC'D BY REGISTRAR<br><b>C. Glen Carter 8431 Georgia Avenue</b>  |  |  |                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | DATE <b>JAN 4 1968</b>  |   |  |

17837

CONTINUED LIST

17837

ACQUITTOMERY

TEXAS

ICE

2-14 3-14

WASHINGTON 2nd 8-14

2nd 8-14

ARLEY

OSWALT

7-1-46

WHITE

MISSISSIPPI

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17328

17327

|   |  |                                   |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>c. LENGTH OF STAY in 1b <u>36 mos.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>   |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1<br>d. STREET ADDRESS <u>12800 Seabury Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First <u>PARELMAN</u> Middle <u>-</u> Last<br>5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/20/1882</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |                                   |  | 4. DATE OF DEATH <u>DEC. 24</u> 19 <u>67</u> Month Day Year  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessness</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> 11. BIRTHPLACE (State or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |                                   |  |  |  |  |  |
| 13. FATHER'S NAME <u>Samuel Parelman</u> 14. MOTHER'S MAIDEN NAME <u>CECILE HALPERN</u> (UNK)   |  |                                   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>KAMUEL T. PARELMAN</u> Address <u>SSA 10607 BOCKNELL DR</u>   |  |                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>Generalized Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                                   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |  |                                   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |                                   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                                   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>  |  |                                   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>MD</u>  |  |  |  |
| 22. DATE SIGNED <u>DEC. 24, 1967</u>  |  |                                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>12/26/67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sharon Cem</u>   |  | 23d. LOCATION (City or town) (County) (State) <u>Neel Cou. Md.</u>     |  |
| 24. FUNERAL DIRECTOR <u>Seabury Funeral Home</u> ADDRESS <u>4217-9 Lee</u>  |  |                                   |  | 25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                        |  |

1932

1932

The following is a list of the  
 names of the persons who  
 have been appointed to the  
 various committees of the  
 Board of Directors of the  
 City of New York for the  
 year 1932.

The following is a list of the  
 names of the persons who  
 have been appointed to the  
 various committees of the  
 Board of Directors of the  
 City of New York for the  
 year 1932.

The following is a list of the  
 names of the persons who  
 have been appointed to the  
 various committees of the  
 Board of Directors of the  
 City of New York for the  
 year 1932.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17329

CERTIFICATE OF DEATH

17328

|   |                                  |   |  |   |  |   |   |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY <b>-----</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |                                  |   | c. LENGTH OF STAY IN lb  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D. C.</b> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>CHEVY CHASE NURS. &amp; CONV. CENTER</b>   |                                  |   |  | d. STREET ADDRESS <b>Washington, D. C.</b><br><b>4000 Mass. Ave., N. W.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED <b>Elizabeth</b> First Middle Last<br>(Type or print) <b>(BETTY) Bobman</b> <b>PARIS</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>12</b> Year <b>19 67</b>   |  |   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/11/02</b>                                    |   | 9. AGE (In years last birthday) yrs.<br><b>65</b>  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Philadelphia, Pa.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Julius Bobman</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No None</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>579-58-8043</b>   |  | 17. INFORMANT<br><b>Robert Paris</b>  |  | Address <b>Sil. Spr. Md.</b><br><b>900 Clintwood Dr.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arterio-sclerosis</b> DUE TO<br>(c) <b>-----</b> |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>5 yrs</b>                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>-----</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>-----</b> , to <b>Dec. 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1967</b> , and that death occurred at <b>7:22</b> M, from causes and on the date stated above.   |                                  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><b>Le Roy Robins</b>  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |  | 22b. DATE SIGNED<br><b>12-12-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Le ROY ROBINS</b>   |                                  |   |  | 22d. ADDRESS<br><b>2480 16th St., N. W., Wash., D. C.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/14/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Roosevelt Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Philadelphia, Pa.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Goldberg Funeral Home</b>  |                                  |   |  | ADDRESS<br><b>4217 9th St., N.W.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 18 1967</b>  |   |
|   |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>  |  |   |   |



13.1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                                 |  |   |  |  |  |  |
|--|--|--|---------------------------------|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                                 |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |                                 |  |   |  |  |  |  |
| 17330  |  |  |                                 |  |   |  |  |  |  |
| 17329  |  |  |                                 |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |                                 |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |                                 |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill-Chase Avenue</u>                                     |  |  |  |  |
| c. LENGTH OF STAY IN 1b. <u>I.D.O.H.</u>   |  |  |                                 |  | d. STREET ADDRESS <u>Bethesda</u>   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  |  |                                 |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Patten</u> Last <u>Patten</u>   |  |  |                                 |  | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1967</u>   |  |  |  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>                    |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>FEB. 18, 1919</u>                                  |  | 9. AGE (In years lost, birthday) yrs. <u>48</u>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter contractor</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>private</u> |                                 | 11. PLACE (County & State, or foreign country) <u>Pennsylvania U.S.A.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |  |  |
| 13. FATHER'S NAME <u>Sidney Patten</u>   |  |  |                                 |  | 14. MOTHER'S MAIDEN NAME <u>Betha</u>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>   |  |  |                                 |  | 16. SOCIAL SECURITY NO. <u>191-18-0846</u>  |  | 17. INFORMANT Address <u>Wife - Elizabeth Patten</u> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                                 |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |  |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> to <u>Dec 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 28, 1967</u> , and that death occurred at <u>5:30</u> M. from causes and on the date stated above.   |  |  |                                 |  |   |  |  |  |  |
| 22a. SIGNATURE <u>Lee J. Donovan</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |                                 |  | 22b. DATE SIGNED <u>12/31/67</u>  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>DR. LEO DONOVAN</u>  |  |  |                                 |  | 22d. ADDRESS <u>13218 WILSON AVE BETHESDA</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  | 23b. DATE THEREOF <u>1-5-68</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem.</u>   |  |  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY Bethesda, Maryland</u>  |  |  |                                 |  | 25a. REC'D BY REGISTRAR <u>DAIAN 5 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>      |  |  |

1933

1933

STATE OF OHIO

1933-1-10

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                               |   |                                     |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Dist. of Co.</u> b. COUNTY <u>✓</u>      |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |                                     |
| c. LENGTH OF STAY IN 1b <u>D.C.A.</u>   |                               | d. STREET ADDRESS <u>115 Wayne Pl. S.E.</u>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print) <u>Genevia Lynn Perminster</u>  |                               | 4. DATE OF DEATH <u>Dec. 22 1967</u>  |                                     |
| 5. SEX <u>female</u>  | 6. COLOR OR RACE <u>negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 15 1967</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                     |
| 13. FATHER'S NAME <u>Samuel L. Perminster</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Dorothy Browder</u>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                               | 16. SOCIAL SECURITY NO. <u>same</u>   |                                     |
| 17. INFORMANT <u>Dorothy Perminster</u>   |                               | Address <u>same</u>   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>491X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u><br>(c) <u>DUE TO</u>   |                               | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |                                     |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D.   |                               | 22. DATE SIGNED <u>12/23/67</u>   |                                     |
| EXAMINER'S NAME (Type)  |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE THEREOF <u>12/26/67</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <u>W. W. CHAMBERS CO. 5117 N. ST. S.E. WASH. D.C.</u>  |                               | 23d. LOCATION (City or Town) (County) (State) <u>BEAVER FALLS, PA.</u>  |                                     |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u>  |                               | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>  |                                     |
| 25b. REGISTRAR'S SIGNATURE  |                               | DATE <u>DEC 29 1967</u>   |                                     |

7-75

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17331

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery County</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>  |                                    |
| c. LENGTH OF STAY IN 1b<br><u>6 days</u>   |                               | d. STREET ADDRESS<br><u>8811 Colesville Rd.</u>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>   |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ruth</u> Middle <u>Z</u> Last <u>Philpott</u>  |                               | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>18</u> Year <u>1967</u>   |                                    |
| 5. SEX<br><u>F.</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>12/8/04</u> |
| 9. AGE (In years lost birthday)<br><u>63</u> yrs.  |                               | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>- -</u>  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |                                    |
| 13. FATHER'S NAME<br><u>H.E. ZERNER</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>MAY RISTON</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                               | 16. SOCIAL SECURITY NO.<br><u>- - -</u>  |                                    |
| 17. INFORMANT<br><u>HAROLD M. PHILPOTT-SEE ITEM #2.</u>  |                               | Address  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute lymphatic leukemia</u><br>2001 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Lymphosarcoma</u><br>DUE TO<br>(c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mos.</u><br><u>15 mos.</u>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>12/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> 19 <u>67</u> , and that death occurred at <u>934</u> M, from causes and on the date stated above.  |                               |  |                                    |
| 22a. SIGNATURE<br><u>G. Lennard Gold</u>   |                               | 22b. DATE SIGNED<br><u>12/19/67</u>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><u>G. Lennard Gold, M.D.</u>   |                               | 22d. ADDRESS<br><u>8641 Colesville Rd., Sil. Spr., Md.</u>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |                               | 23b. DATE THEREOF<br><u>12-19-1967</u>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Park Cemetery</u>   |                               | 23d. LOCATION (City or Town) (County) (State)<br><u>New Castle, Pa.</u>  |                                    |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>  |                               | 25a. RECEIVED BY REGISTRAR<br><u>DEC 26 1967</u>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                               | DATE   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17532

CERTIFICATE OF DEATH

1881

Montgomery County  
Silver Spring  
Vol. 1000  
Page 1000  
Date of Death  
Cause of Death  
Place of Death

John Smith  
Age 45  
Male  
White  
Married  
Occupation  
Residence  
Date of Birth  
Date of Death  
Cause of Death  
Place of Death  
Signature  
Witness

Filed for Record  
at the Office of the  
County Clerk  
this 1st day of  
January 1881

17333

## CERTIFICATE OF DEATH

Reg. Dist. No. 17332

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b>  |   | d. STREET ADDRESS<br><b>3732 Manor Road</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jean</b> Middle <b>R.</b> Last <b>Pitzer</b>  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>5</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-3-78</b>                                     |
| 9. AGE (In years lost birthday) yrs. <b>89</b>  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - - - -   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Samuel Rixey</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary F. Wise</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br>- - - - -   |  |
| INFORMANT<br><b>Miss Frankie R. Keyser-Niece-</b>   |   | Address <b>8320 26th Ave. Adelphi, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic heart disease</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>20 yrs.</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>2/12</b> , 19 <b>65</b> , to <b>12/5</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>12/3</b> , 19 <b>67</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4830 V Street, N. W. Washington, D. C. 20007</b> DATE SIGNED <b>12-5-67</b>   |   |  |  |
| ACTUAL SIGNATURE <b>John D. Griswold</b>  |   | M.D. <b>John D. Griswold, M. D.</b>  |  |
| PHYSICIAN'S NAME (Type)   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 22b. DATE THEREOF<br><b>12-7-1967</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Culpepper, Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisc. Ave. N.W. Wash. DC</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 11 1967</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14333

CERTIFICATE OF DEATH

14333

APR 11 1964

1044 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

17334 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17333

|  |                                  |   |  |   |   |   |   |  |
|--|----------------------------------|---|--|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  |   | c. LENGTH OF STAY IN 1b                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6017 Neilwood Drive</b>   |                                  |   |  | d. STREET ADDRESS<br><b>6017 Neilwood Drive</b>   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MARY PLATT</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 8 1967</b>  |   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Aug. 30, 1890</b> |   | 9. AGE (In years last birthday)<br><b>77</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Russia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |  |
| 13. FATHER'S NAME<br><b>Zalman Landow</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie ? ? ?</b>   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>169-16-8259 D</b>   |  | 17. INFORMANT<br><b>9332 Harvey Road Silver Spring, Maryland</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - Aneurysm</b><br>DUE TO <b>Ext. Hypertensive Heart Dis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-24</b> , 1967, to <b>12-5</b> , 1967, that (I) (we) lost saw the deceased alive on <b>12-5</b> 1967, and that death occurred at <b>6:00</b> PM, from causes and on the date stated above.   |                                  |   |  |   |   |   |   |  |
| 22a. SIGNATURE<br><b>Isidore Shulman</b>   |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |   | 22b. DATE SIGNED<br><b>12-9-1967</b>  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Isidore Shulman, M. D.</b>  |                                  |   |  | 22d. ADDRESS<br><b>915 19th Street N. W. Washington, D. C.</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12-10-1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Park</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Falls Church Va.</b>                            |   |  |
| 24. FUNERAL DIRECTOR<br><b>Goldberg Funeral Home</b>   |                                  |   |  | ADDRESS<br><b>4217 9th St. N.W.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 11 1967</b>  |   |  |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>  |   |   |   |  |

15334

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RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
JAN 11 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LAYTONSVILLE</b>   |                                     |
| c. LENGTH OF STAY IN 1b<br><b>14 DAYS</b>   |                                  | d. STREET ADDRESS<br><b>-</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>LAMAR</b> Last <b>PLUMMER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>6</b> Year <b>1967</b>   |                                     |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-13-92</b> |
| 9. AGE (In years lost birthday)<br><b>75</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CARPENTER</b>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                     |
| 13. FATHER'S NAME<br><b>HOWARD A. PLUMMER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>R. IDA CRAWFORD</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES</b> <b>WW I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-10-8492</b>   |                                     |
| 17. INFORMANT<br><b>MEDICAL RECORD DEPT.</b>  |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident - basilar artery</b><br>331X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Bronchopneumonia, Diabetes mellitus, chronic lymphatic leukemia</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>Dec. 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6, 1967</b> , and that death occurred at <b>3:03 P.M.</b> , from causes and on the date stated above.   |                                  |   |                                     |
| 22a. SIGNATURE<br><b>Frederick Moomau M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>12-6-67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>FREDERICK MOOMAU, M. D.</b>  |                                  | 22d. ADDRESS<br><b>MEDICAL CENTER, SANDY SPRING, MD.</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12-9-67</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laytonsville</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Laytonsville Mont Md.</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonsville, Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 8 1967</b>  |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>  |                                  |   |                                     |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18-21 Film 396  
1-15-68 am

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17335

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b><br>MARYLAND  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>23 hrs.</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Spring</b> 15.1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |                                  |  | Box ADDRESS<br><b>101, Sandy Spring Md.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 3. NAME OF DECEASED<br>(Type or print) <b>George Alexander Powell</b><br>First Middle Last  |                                  |  | 4. DATE OF DEATH<br><b>12 9 19 67</b><br>Month Day Year   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH<br><b>6/11/08</b>  | 9. AGE (In years lost birthday)<br><b>59</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dishwasher</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital 7</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Sandy Spring Md.</b>   |   |
| 13. FATHER'S NAME<br><b>A. Chase</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Imma Powell</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Brother/Milton Powell/Sandy Spring Md</b><br>Address                                     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock and acute diffuse purulent</b><br><b>816.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>peritonitis due to traumatic rupture</b><br>DUE TO (c) <b>of ileum</b>   |                                  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Deceased, driver, collided head-on with another auto.</b> |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>4:48 p.m. 12-8 19 67</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b>                      |   |
|   |                                  | 20f. (City or town)<br><b>Rockville</b>  |   | (County) <b>Montg.</b> (State) <b>Md.</b>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |   |  |   |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED  |   |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (City, County, State)<br><b>Rockville, Md.</b>  |   | <b>DEC. 10, 1967</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/13/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ash Memorial Cemetery</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert L. Sworden</b>  |                                  | ADDRESS<br><b>Rockville, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 15 1967</b>  |   |
|   |                                  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

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Figure 7. Example of a single trial.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17337

17336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbar papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |   |   |   |  |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>West Virginia</u> b. COUNTY <u>Delbarton</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  |   |  | c. LENGTH OF STAY IN 1b<br><u>29 Days</u>   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Route #1, Box 191C</u>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Harold</u> Middle <u>(NMN)</u> Last <u>Preece, Jr.</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>26</u> Year <u>19 67</u>   |   |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1957</u><br><u>22 September</u> | 9. AGE (In years last birthday)<br><u>10</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Student</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>--</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>West Virginia</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Harold Preece, Sr.</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Peggy Sue Runyon</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT <u>The Medical Records</u><br><u>The Clinical Center, Bethesda, Maryland</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration, Pneumonia</u><br><u>2043</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Gastrointestinal Hemorrhage</u> DUE TO<br>(c) <u>Acute Lymphocytic Leukemia</u> |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 Hours</u><br><u>24 hours</u><br><u>40 months</u>        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Miliary tuberculosis - inactive.</u>   |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>27 November, 19 67</u> , to <u>26 Dec.</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>26 December</u> 19 <u>67</u> , and that death occurred at <u>5:45M</u> , from causes and on the date stated above.   |                                  |   |  |   |   |   |  |
| 22a. SIGNATURE<br><u>Richard H. Creech</u>  |                                  |   |  | 22b. DATE SIGNED<br><u>1967</u><br><u>27 December</u>   |   | 22c. PHYSICIAN'S NAME (Type)<br><u>Richard H. Creech, MD.</u>                                     |  |
| 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |                                  |   |  | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>              |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removed</u>   |                                  | 23b. DATE THEREOF<br><u>12-28-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Delbarton W. Va.</u>                          |  |
| 24. FUNERAL DIRECTOR<br><u>W.W. Chambers Co. Inc</u>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>1400 Chapin St. NW Wash, D.C.</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> 17338<br/> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> Items 13a,b,c, &amp; 1/9/88 Film G396<br/> <b>CERTIFICATE OF DEATH</b><br/> 17337 </div>   |  |  |  |  |  |   |  |  |  |  |  |   |                                |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Logan</b>   |  |  | First <b>Presler</b>   |  |  | Last <b>Presler</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>December</b> Day <b>20</b> Year <b>1967</b>                    |  |  | 2b. HOUR<br>M                                     |                                |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>Feb. 8, 1882</b>   |  |  | 6. AGE (In years last birthday) <b>85</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.  |  |  |   |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Resmor Saw Grosvenor Lane</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Lawyer- U.S. Gov't.</b>                                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>                                      |  |  |   |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Montgomery</b>  |  |  | 13c. CITY OR TOWN <b>Bethesda</b>   |  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  | 13e. STREET AND NUMBER <b>3471 Grosvenor Lane</b> |                                |
| 14. FATHER'S NAME<br>First <b>Hiram</b> Middle <b>Presler</b> Last <b>Presler</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mathilde</b> Middle <b>Herbert</b> Last <b>Herbert</b>                      |  |  |   |  |  |  |  |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.<br><b>579-62-6656-T</b>   |  |  | 17. INFORMANT<br><b>Capt. Irving Presler</b> Address <b>10861 Springknoll Dr. Potomac, Md.</b>  |  |  |  |  |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4500</b> IMMEDIATE CAUSE (a) <b>Bilateral Bronchial Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Senile Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>Approximate interval between onset and death <b>36 hours</b> |  |  |  |  |  |   |  |  |  |  |  |   |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>Diabetes Mellitus</b>   |  |  |  |  |  |   |  |  |  |  |  |   |                                |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |   |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>43</b> , to <b>Dec 20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-20</b> , 19 <b>67</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |  |  |   |  |  |  |  |  |   |                                |
| 22b. SIGNATURE<br><b>P.P. Andrews M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |   |  |  | 22c. DATE SIGNED<br><b>12-20-67</b>  |  |  |   |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>P.P. ANDREWS M.D.</b>   |  |  |  |  |  |   |  |  | 22e. ADDRESS<br><b>WASHINGTON D.C.</b>   |  |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12-22-1967</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>                     |  |  |   |                                |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 28 1967</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |                                |

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1334

UNITED STATES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>1 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>d. STREET ADDRESS <u>10812 Hobson St</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Albert</u> Middle <u>E.</u> Last <u>Price</u>  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>27</u> Year <u>1967</u>  |   |
| 5. SEX <u>M.</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>8/6/97</u> 9. AGE (In years last birthday) <u>70</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Emp. Retired</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>John Price</u>  |  | 14. MOTHER'S MARDEN NAME <u>Hanna E. Smith</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW2 Army</u>  |  | 16. SOCIAL SECURITY NO. <u>578 10 1402</u>  |   |
| 17. INFORMANT <u>Pamela Price</u>  |  | Address <u>Same as above</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO (b) <u>CONGESTIVE HEART FAILURE</u><br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>2 yrs</u><br><u>10 yrs</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>63</u> , to <u>12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>67</u> , and that death occurred at <u>5pm</u> M, from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE <u>John E. Everett</u>  |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>  |  | 22d. ADDRESS <u>Kensington, Md. 9400 Conn. Ave</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>   | 23b. DATE THEREOF <u>12-30-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>            |
| 24. FUNERAL DIRECTOR ADDRESS <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W.</u>  |  | 25a. REC'D BY REGISTRAR <u>Wash D C</u><br>DATE <u>JAN 3 1968</u>   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                               |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17340

17339

|   |                                  |   |   |  |  |   |  |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Downingtown</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  |   | c. LENGTH OF STAY IN 1b<br><u>72 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Downingtown</u> <u>75-3</u> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |                                  |   |   | d. STREET ADDRESS<br><u>R.D. #2</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Richard</u> Middle <u>Andrew</u> Last <u>Przemyski, Jr.</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>3</u> Year <u>1967</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>23 December 1948</u> |  | 9. AGE (In years last birthday)<br><u>18 yrs.</u>  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Student</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>England</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Richard A. Przemyski, Sr.</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Eva Lada</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>183-40-8572</u>   |   | 17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral</u> bronchopneumonia<br><u>2043</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Septicemia with renal and perisplenic abscesses</u> DUE TO<br>(c) <u>Acute myelogenous leukemia</u> DUE TO |                                  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>2 weeks</u><br><u>2 years</u>              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Cerebral edema (24 hours)</u>  |                                  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 22, 1967</u> , to <u>Dec. 3, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 3, 1967</u> , and that death occurred at <u>10:50M</u> , from causes and on the date stated above.  |                                  |   |   |  |  |   |  |
| 22a. SIGNATURE <u>David L. Lilien</u>   |                                  |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> PM                 |  | 22b. DATE SIGNED<br><u>4 December 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>David L. Lilien, MD</u>   |                                  |   |   | 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Dec. 7, 1967</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Joseph's Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Downingtown, Chester, Pa.</u>                 |  |
| 24. FUNERAL DIRECTOR<br><u>Ralph W. Balston, 107 W. Lancaster Ave. Downingtown, Pa. 19335</u>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 7 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

1133

1133

*John*

*John*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 18&21 Film 396

12-28-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17341

# CERTIFICATE OF DEATH

17340

|  |                                     |   |  |   |   |   |   |
|--|-------------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                     |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>New York</u> b. COUNTY <u>----</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                     | c. LENGTH OF STAY IN 1b<br><u>12 Days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Brooklyn</u>                                     |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center (N. I. H.)</u>  |                                     |   |  | d. STREET ADDRESS<br><u>630 E. 93rd Street</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Samuel</u> Middle <u>(NMN)</u> Last <u>Rappel</u>  |                                     |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>1</u> Year <u>1967</u>   |   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9 November 1912</u>                             |   | 9. AGE (In years last birthday)<br><u>55</u> yrs. | IF UNDER 1 YEAR<br>Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>             |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Service</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>William Rappel</u>   |                                     |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ida Meyer</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>1943-45</u>   |                                     | 16. SOCIAL SECURITY NO.<br><u>116-07-7878</u>   |  | 17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u><br><u>4211</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calcific Aortic Stenosis, Post-Operative Aortic Valve Replacement</u> DUE TO<br>(c) <u>Atherosclerosis</u> |                                     |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                     |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>---</u>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)              |   |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>19 November 1967</u> to <u>1 December 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 December 1967</u> , and that death occurred at <u>2:15 A.M.</u> from causes and on the date stated above.  |                                     |   |  |   |   |   |   |
| 22a. SIGNATURE<br><u>James C. A. Fuchs</u>   |                                     |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |   | 22b. DATE SIGNED<br><u>12/1/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James C. A. Fuchs, M. D.</u>  |                                     |   |  | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>12-3-67</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Mt. Carmel cemetery</u>  |  | 23d. LOCATION (City or town) (County) (State)<br><u>Brooklyn New York</u>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><u>Bernard Danzansky And Sons</u>  |                                     |   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 4 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Jones</u>  |   |

11381

11381

CONFIDENTIAL

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

APPROVED :

REMARKS :

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

7. [Illegible text]

8. [Illegible text]

9. [Illegible text]

10. [Illegible text]

11. [Illegible text]

12. [Illegible text]

Medical Examiner Dr. Belden Reap called concerning this death and he authorized me to sign this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i><br>c. LENGTH OF STAY IN lb <i>7 years</i><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1712 Alberti Drive</i>  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> <i>15-1</i><br>d. STREET ADDRESS <i>1712 Alberti Drive</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <i>Marie Rausch</i><br>First Middle Last<br>4. DATE OF DEATH <i>Dec 16 1967</i><br>Month Day Year   |  |  |  |  | 5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>April 9, 1875</i> 9. AGE (In years last birthday) <i>92</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Chicago, Illinois</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>  |  |  |  |  | 13. FATHER'S NAME <i>Thomas Podlesak</i> 14. MOTHER'S MAIDEN NAME <i>Anna Cesal</i>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <i>310-05-56660</i> 17. INFORMANT <i>Frank C. Rousch</i> Address <i>1712 Alberti Drive Silver Spring, Md.</i>   |  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i><br>332X<br>DUE TO (b) <i>Cerebro-sclerosis</i> Undetermined<br>DUE TO (c) <i>Generalized Arterio-sclerosis</i> Undetermined<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senile Dementia</i> |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April 1966</i> , to <i>Dec 16, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 4 1967</i> , and that death occurred at <i>2:00</i> M, from the causes and on the date stated above.   |  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE <i>George L. Ball</i> 22b. DATE SIGNED <i>Dec 16, 1967</i><br>M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  | 22c. PHYSICIAN'S NAME (Type) <i>George L. Ball</i> 22d. ADDRESS <i>10620 Georgia Ave Silver Spring, Md.</i>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans-Burial</i> 23b. DATE THEREOF <i>Dec. 20, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Emblem Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Elmhurst Illinois</i>  |  |  |  |  | 24. FUNERAL DIRECTOR <i>Clark &amp; Wilson</i> ADDRESS <i>8434 Georgia Avenue</i> 25a. REC'D BY REGISTRAR <i>DEC 26 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  |  |  |  |

1388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Penn Shop Road Route 3</u>                             |  |  |  | 15-1   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Colonial Villa</u>  |  |   |  |   |  | d. STREET ADDRESS   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ralph</u> Middle <u>Reece</u> Last <u>Reece</u>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>29</u> Year <u>1967</u>  |  |  |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>white</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4-17-91</u>  |  | 9. AGE (In years last birthday)<br><u>86</u> yrs.                              |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Seaman Ret</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Newark, New Jersey</u>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>      |  |  |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>195-07-7004-1</u>   |  | 17. INFORMANT<br><u>Miss Eleanor Reece</u>  |  |  | Address <u>5029 Trindle Rd. Mechanicsburg, Pa.</u> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive gastrointestinal bleeding</u><br>DUE TO (b) <u>Recurrent CA of stomach with liver &amp; node metastases</u><br>DUE TO (c) <u>metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u>                                       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar 30, 1967</u> , to <u>12 30</u> , 1967, that (I) (we) last saw the deceased alive on <u>12 28</u> 1967, and that death occurred at <u>11:05</u> M, from causes and on the date stated above.   |  |   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>Benne G. Bendler</u>  |  |   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |  | 22b. DATE SIGNED<br><u>12-30-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Benne G. Bendler, M. D.</u>   |  |   |  |   |  | 22d. ADDRESS<br><u>10820 Ga. Ave Wheaton Md</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |  | 23b. DATE THEREOF<br><u>Dec. 30, 1967</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln</u>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Price George, Maryland</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u>  |  |   |  |   |  | ADDRESS<br><u>2434 Georgia Avenue Silver Spring, Md.</u>  |  | 25a. JAN 8 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                       |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17344

CERTIFICATE OF DEATH

17343

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #3 Bethesda</u>  |  |
| c. LENGTH OF STAY IN 1b <u>27 days</u>   |   | d. STREET ADDRESS <u>12824 Fern Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edna</u> Middle <u>Grace</u> Last <u>Seed</u>  |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>28</u> Year <u>1967</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Aug. 24 - 1895</u>                                   |
| 9. AGE (In years last birthday) <u>72</u> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Henry Lepers</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Mollie Priscilla White</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>214-32-9743</u>  |  |
| 17. INFORMANT <u>Mrs. Annett</u> Address <u>12824 Fern Drive Bethesda</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u><br>157X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____ |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> , 19 <u>67</u> , to <u>12/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> A.M., from causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE <u>Robert C. Daddario</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED <u>12/29/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>   |   | 22d. ADDRESS <u>5413 CEDAR LANE BETHESDA</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>1/2/68</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Herndon Fairfax Va.</u> |
| 24. FUNERAL DIRECTOR <u>William C. Hiltz, Painesville, Md.</u>   |   | 25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*[Faint, mostly illegible text covering the main body of the page, possibly bleed-through from the reverse side.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

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|--|--|---|--|---|--|--|--|
| 17345  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  | CERTIFICATE OF DEATH  |  | 17345  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>WASH DC</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING WASH. DC</u> 47.3<br>d. STREET ADDRESS <u>3609 Nichols Ave</u><br><u>2934 HEATH LAWN RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>RALPH A REINHART SR</u><br>First Middle Last   |  |   |  | 4. DATE OF DEATH <u>12 25 1967</u><br>Month Day Year  |  |  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>4-21-95</u><br>Yrs.                                |  |
| 9. AGE (In years last birthday) <u>72</u> yrs.   |  | 10. IF UNDER 1 YEAR Months Days   |  | 11. IF UNDER 24 HRS. Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retd</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Service</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>        |  |
| 13. FATHER'S NAME <u>Lawrence J. Reinhart</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Stella E. Watson</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWI 65-17-4-22-14</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>65-17-4-22-14</u>  |  | 17. INFORMANT <u>Ralph A. Reinhart Jr.</u><br>Address                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Lobular pneumonia</u><br><u>4200</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart</u> DUE TO<br>(c) <u>Disease</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u><br><u>years</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>myocardium</u>   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  | 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1967</u> to <u>Dec 25, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 25 1967</u> and that death occurred at <u>11:30 PM</u> from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <u>John J. Curry</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <u>12/26/67</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>  |  |   |  | 22d. ADDRESS <u>70620 Georgia Ave SE</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12-29-1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>Washington DC</u>     |  |
| 24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>Wash DC</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                          |  |

REPORT OF THE AGENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G396 12/20/81 KK  
CERTIFICATE OF DEATH

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>VIRGINIA</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CHEVY CHASE</b>  |  | c. LENGTH OF STAY IN 1b<br><b>4 mos. 9 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>BETHESDA-SILVER SPRING NURSING HOME</b>  |  | d. STREET ADDRESS<br><b>3430 PICKETT RD.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NON</b> Middle <b>DEKNER</b> Last <b>DEKNER</b>   |  | 4. DATE OF DEATH<br>Month <b>DEC</b> Day <b>5</b> Year <b>1967</b>  |   |
| 5. SEX <b>FE</b>  | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-9-82</b>   |
| 9. AGE (In years last birthday) <b>85 8/27</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>ILLINOIS</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William R. Taylor</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Day</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNKNOWN</b>   |  | 16. SOCIAL SECURITY NO.<br><b>375-14-6281A</b>  |   |
| 17. INFORMANT<br><b>PATIENT'S CHART</b>   |  | Address<br><b>8700 JONES MILL RD. CHEVY CHASE, MD.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO <b>Cerebral Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b><br>(c) <b>Generalized Arteriosclerosis</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MIN</b><br><b>5 YRS</b><br><b>10 YRS.</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town) (County) (State)  |  |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/67</b> , 19 to <b>12/5/67</b> , that (I) (we) last saw the deceased alive on <b>10/25/67</b> , 19, and that death occurred at <b>6:10 PM</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Henry C. Scruggs MD</b>  |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Henry C. Scruggs MD</b>  |  | 22d. ADDRESS<br><b>5413 Cedar Lane Bethesda Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE THEREOF<br><b>12/7/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State)<br><b>Nokomis, Ill.</b>                             |
| 24. FUNERAL DIRECTOR<br><b>Joseph J. Lewis's Sons Inc</b>   |  | 25a. REC'D BY REGISTRAR<br><b>Wash., D.C.</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | DATE<br><b>DEC 11 1967</b>  |   |

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 see Birth Cert. MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17347

CERTIFICATE OF DEATH

17346

|   |                                |   |                                      |
|---|--------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>                    |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA (RURAL)</b>   |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA (RURAL) / Leonardtown 18.2</b>                              |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>NAVAL HOSPITAL</b>   |                                | d. STREET ADDRESS<br><b>NAVAL HOSPITAL Park Ave.</b>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANDREZ</b> Middle <b>MONTAG</b> Last <b>RICE</b>  |                                | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>15</b> Year <b>19 67</b>   |                                      |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEG</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>15 DEC 67</b> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                | 9. AGE (In years lost birthday) yrs. <b>1</b>   |                                      |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                                | 11. BIRTHPLACE (County & State, or foreign country)<br><b>SAINT MARY'S md</b>   |                                      |
| 13. FATHER'S NAME<br><b>ELMER M. RICE</b>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                                | 16. SOCIAL SECURITY NO.   |                                      |
| 17. INFORMANT<br><b>ALBERTA MARIE RICE</b>  |                                | Address<br><b>PARK AVE LEONARDTOWN MD</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE BILATERAL ATELECTOSIS</b><br><b>762.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY &amp; IMMATURITY</b><br>DUE TO (c) _____ |                                | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>15 DEC</b> , 19 <b>67</b> , to <b>15 DEC</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>15 DEC</b> , 19 <b>67</b> , and that death occurred at <b>1110 PM</b> , from causes and on the date stated above.  |                                |   |                                      |
| 22a. SIGNATURE<br><b>G.P. SWARTZ, MD, MC, USN</b>   |                                | 22b. DATE SIGNED<br><b>16 DEC 1967</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>G.P. SWARTZ, MD, MC, USN</b>   |                                | 22d. ADDRESS<br><b>NAVAL HOSPITAL, BETHESDA, MD.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                | 23b. DATE THEREOF<br><b>Dec. 24, 1967</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethesda Methodist Cemetery</b>  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Leonardtown Maryland</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>Mattingley Funeral Home, Leonardtown, Md</b>   |                                | 25a. REC'D BY REGISTRAR<br><b>DEC 21 1967</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                |   |                                      |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

17348

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17347

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>   |  |
| c. LENGTH OF STAY in 1b. <u>15.11</u>  |   | d. STREET ADDRESS <u>12709 Glen Mill Rd.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Mary Anne Kicketts</u>  |   | 4. DATE OF DEATH <u>Dec. 24</u> 19 <u>67</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>March 31, 1932</u>   |
| 9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 10. AGE (In years last birthday) <u>35</u> yrs.   | IF UNDER 1 YEAR   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Auditor</u>   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>  | Months  | Days   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  | Hours   | Min.   |
| 13. FATHER'S NAME <u>Jandrus Kidd</u>  | 14. MOTHER'S MAIDEN NAME <u>Effie</u>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  | 16. SOCIAL SECURITY NO. <u>no</u>   | 17. INFORMANT <u>Effie</u> Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries - Severe</u><br><u>825.9</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Trauma from Auto Accident</u><br>DUE TO (c) <u>Highway</u>  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>5:35 p.m. 12/24 1967</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>   | 20f. (City or town) <u>Darsonville</u> (County) <u>Montgomery</u> (State) <u>MD</u>            |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE <u>John B. Ball</u>   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22. DATE SIGNED <u>12/24/67</u>  |
| EXAMINER'S NAME (Type) <u>John B. Ball</u>   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |
|  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |
|  | Address (Street, city, town, or county)   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>12/29/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Monocent</u>  | 23d. LOCATION (City or Town) <u>Beallsville</u> (County) <u>Montgomery</u> (State) <u>MD</u>   |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>  | ADDRESS <u>Ernest C. Gartner Gaithersburg Rd</u>  |   | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |
|  | DATE <u>DEC 28 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |  |
| c. LENGTH OF STAY IN 1b <u>108 days</u>  |  | d. STREET ADDRESS <u>3109 Verona Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Randolph Hills Nursing Home</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Antionette</u> First <u>C</u> Middle <u>Rodgers</u> Last  |  | 4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1967</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-12-1889</u>   |
| 9. AGE (In years lost birthday) <u>78</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  | 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>                          |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>Wilson Robey</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Susan Barrett</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>220-54-0219</u>   |  |
| 17. INFORMANT <u>Mrs. Frances E. Haller</u>  |  | Address <u>3109 Verona Drive Silver Spring, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br><u>451X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aneurysm of Aorta</u><br>(c) <u>Atherosclerosis of Aorta</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1wk</u><br><u>YRS.</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Cerebral Vascular Accident Parkinsonism</u>  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>67</u> , and that death occurred at <u>3:15</u> M, from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <u>Raymond T. Benack</u> M.D.   |  | 22b. DATE SIGNED <u>12/29/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>   |  | 22d. ADDRESS <u>4115 Clie Drive, Wheaton, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Jan. 2, 1968</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>                           |
| 24. FUNERAL DIRECTOR <u>Thomas J. Thomas</u> Address <u>84 Georgia Ave</u>   |  | 25a. REC'D BY REGISTRAR <u>JAN 8 1968</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |

1332

CHIEF OF DEPT.

1332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |   |   |  |
|--|--|---|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |   |  |
| 17350  |  |   |   |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓ |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gaithersburg</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>5yrs. 5mo.</b>    |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> 032                                       |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Asbury Methodist Home</b>   |  |   |   |   | d. STREET ADDRESS<br><b>9811 Hartford Road</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Mrs. Mary Alice Schneider</b><br>First Middle Last  |  |   |   |   | 4. DATE OF DEATH <b>Dec 2 1967</b><br>Month Day Year   |  |   |   |  |
| 5. SEX <b>female</b>   |  | 6. COLOR OR RACE <b>white</b>                       |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>August 25 1894</b>                                 |   | 9. AGE (In years last birthday) <b>73</b> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                 |   |  |
| 13. FATHER'S NAME<br><b>George H. Shimp</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Iva M. Montgomery</b>   |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |   | 16. SOCIAL SECURITY NO.<br><b>213-56-7496 T</b> |   | 17. INFORMANT <b>Methodist Home Records</b> Address  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO<br>(c) <b>2 YRS.</b> |  |   |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19 p.m.  |  |   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/1/63</b> , 19 to <b>12/2/67</b> , 19, that (I) (we) last saw the deceased alive on <b>11/28/67</b> , 19, and that death occurred at <b>8:30 A.M.</b> from causes and on the date stated above.  |  |   |   |   |  |  |   |   |  |
| 22a. SIGNATURE<br><b>Henry C. Scruggs, M.D.</b>  |  |   |   |   | 22b. DATE SIGNED<br><b>12/2/67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Henry C. Scruggs, M.D.</b> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF<br><b>12-5-67</b>                 |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FAZ Road</b>   |  | 23d. LOCATION (City or town) (County) (State)<br><b>BALLO Mt</b>       |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 5 1967</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>C. F. EVANS &amp; SON 8802 NORTON RD</b>  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |  |

17350

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RECEIVED 20 DECEMBER 1951

Bellevue

Bellevue

Montgomery

Bellevue

Dr. J. M.

Bellevue

1951 National Road

Agency National Road

Bellevue

Bellevue

Bellevue

August 25 1951

Female

U.S.A.

Virginia

Live N. Montgomery

George H. Shing

173-26-7-96 7

Henry C. Shing

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Washington</u> b. COUNTY <u>DC</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia.</u>  |  |
| c. LENGTH OF STAY in lb <u>1 yr 5 mo 13 da</u>  |  | d. STREET ADDRESS <u>3051 Idaho Ave. NW</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Eleanor F. Schnoor</u>   |  | 4. DATE OF DEATH <u>Dec 20 1967</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/6/1887</u>   |
| 9. AGE (In years last birthday) <u>80</u> yrs.  |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Rochester N.Y.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>US</u>   |  |
| 13. FATHER'S NAME <u>Frank E. Warth</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Mary T. Weigel</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>114 143748</u>  |  |
| 17. INFORMANT <u>RANDOLPH HILLS NURSING HOME'S RECORDS</u>  |  | Address <u>  </u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO <u>331X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO (c) <u>  </u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u><br><u>6 months</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>66</u> , to <u>12/20</u> , 19 <u>67</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>12/20</u> 19 <u>67</u> , and that death occurred at <u>8 A</u> .M., from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>Raymond T. Benack</u>   |  | 22b. DATE SIGNED <u>12/20/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>  |  | 22d. ADDRESS <u>4115 Colie Drive, Wheaton, Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>Dec. 22, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Rochester, New York.</u>                      |
| 24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>   |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |
| ADDRESS <u>2222 Wis. Ave. N.W. Wash.</u>  |  | DATE <u>JAN 2 1968</u>   |  |

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RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: ASST. DIR. FOR EXTENSION OF CREDIT  
MAIL ROOM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b><br>c. LENGTH OF STAY in 1b<br><b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Sanitarium and Hospital</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Annapolis</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis, Junction (Annapolis)</b><br>d. STREET ADDRESS<br><b>Box 46</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Hugo Herman Schwarz</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 22 19 67</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>10-26-98</b>            |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Government</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Germany</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>America</b>  |  |
| 13. FATHER'S NAME<br><b>Carl Schwarz</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Teresa Knitzinger</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No German Navy</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Patent's chart</b>  |  |
| 17. INFORMANT<br><b>Patent's chart</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b><br>DUE TO <b>Acute myocardial infarct</b><br>(b) <b>Anterior chest heart disease</b><br>DUE TO <b>Anterior chest heart disease</b><br>(c) <b>Anterior chest heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic bronchitis, emphysema</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>Dec. 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Dec. 22</b> 19 <b>67</b> , and that death occurred at <b>9:31</b> P.M., from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Abraham W. Danish</b>   |                                  | 22b. DATE SIGNED<br><b>Dec. 23, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ABRAHAM W. DANISH</b>   |                                  | 22d. ADDRESS<br><b>1106 SPRING ST. S.S. Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12/23/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT LINCOLN CREMATORY</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>RODG MD</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur D. Jones</b>   |                                  | 25a. RECEIVED BY REGISTRAR<br><b>DEC 27 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |                                  | 25c. ADDRESS<br><b>350 WASH BLVD LAUREL, MD</b>   |  |

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UNITED STATES OF AMERICA

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(1)

UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
HEADQUARTERS  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Washington, D.C.</b> COUNTY <b>D.C.</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda, Maryland</b>   |                                  | d. STREET ADDRESS<br><b>1600 16th Street, N.W.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>(NMN)</b> Last <b>Scrippens</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>19 March 1925</b> |
| 9. AGE (In years last birthday) yrs. <b>42</b>   |                                  | 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Photo Lithographer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lithographic Co.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Michael Scrippens</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Kohan</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1943-45</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>199-14-3960</b>  |  |
| 17. INFORMANT<br><b>The Medical Records</b>  |                                  | 18. ADDRESS<br><b>The Clinical Center, Bethesda, Maryland</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO<br>(b) <b>Aortic Insufficiency</b><br>DUE TO<br>(c) <b>Rheumatic Valve Disease</b>                         |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>12 years</b><br><b>20 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>8 days following open heart surgery for aortic valve replacement.</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>19 November 19 67</b> , to <b>23 Dec.</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>23 December 19 67</b> , and that death occurred at <b>10:10</b> , from causes on and on the date stated above. |                                  |  |  |
| 22a. SIGNATURE<br><b>Eric H. Johnson</b>   |                                  | 22b. DATE SIGNED<br><b>23 December 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Eric H. Johnson, MD</b>   |                                  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12-27-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's G. C. Cem.</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pringle, Penna</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Gude</b>   |                                  |  |  |

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RECEIVED - DEPT. OF AGRICULTURE

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.  
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing agricultural matters, possibly related to plant industry or pest control.]

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17354

|  |                               |  |                                 |   |  |   |                             |
|--|-------------------------------|--|---------------------------------|---|--|---|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>  |                               |  |                                 | c. LENGTH OF STAY IN 1b <b>D.O.A.</b>   |  |   |                             |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>  |                               |  |                                 | d. STREET ADDRESS <b>717 BAYFIELD STREET</b>  |  |   |                             |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>  |                               |  |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |                             |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE BEALE SEEK</b>   |                               |  |                                 | 4. DATE OF DEATH Month Day Year <b>12 - 4 19 67</b>   |  |   |                             |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>11-9-97</b> | 9. AGE (In years last birthday) <b>70</b> yrs.  | IF UNDER 1 YEAR Months Days Hours Min. |   | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                |                             |
| 13. FATHER'S NAME <b>RICHARD SEEK</b>  |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <b>ISABEL COLE</b>   |  |   |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>579-22-8604</b>   |                                 | 17. INFORMANT <b>MAY SEEK - NIECE</b>   |  | Address <b>SAME</b>   |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c)  |                               |  |                                 |   |  |   |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                 |   |  |   |                             |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |   |  |   |                             |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work   |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                      |                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                 |   |  |   |                             |
| ACTUAL SIGNATURE <b>Belden R. Reap</b>   |                               | M.D. <b>BELDEN R. REAP, M.D.</b>   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22. DATE SIGNED <b>DEC. 4, 1967</b>                                       |                             |
| EXAMINER'S NAME (Type) <b>BELDEN R. REAP</b>   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                 | Address (City or town) (County) (State) <b>Wheaton, Md.</b>   |  |   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Dec 7, 1967</b>   |                                 | 23c. NAME OF CEMETERY OR CREMATORY <b>Colesville Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Colesville, Maryland</b> |                             |
| 24. FUNERAL DIRECTOR <b>John B. Thomas</b>   |                               | Address <b>2434 Georgia Avenue Silver Spring, Maryland</b>   |                                 | 25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                           |                             |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17355

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|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                     |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>18 days/hrs</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 151 |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hosp.</u>  |  |   |  | d. STREET ADDRESS <u>501 Sligo Ave</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Kimberly Ruth Seck</u>   |  | First Middle Last                               |  | 4. DATE OF DEATH <u>12 20 1967</u>  |  | Month Day Year  |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |  | 8. DATE OF BIRTH <u>9-17-61</u> 6 yrs.  |  |  |  |
| 9. AGE (In years last birthday) <u>6</u>  |  | 10. KIND OF BUSINESS OR INDUSTRY <u>Student</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |
| 13. FATHER'S NAME <u>Theodore Seck</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Pauline <del>Seck</del> VANCE</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO. <u>none</u>   |  | 17. INFORMANT <u>Theodore Seck</u> Address <u>2d. Hospital Records</u>                                    |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Toxic Reaction to Conflagration</u><br>916.0 DUE TO (b) <u>Burns of 65% of Body</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Surface</u>   |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased playing with electric stove and clothing caught fire</u> |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>10:30 a.m. 12-2-1967</u>  |  |   |  | 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>                        |  |  |  |
| 20f. (City or town) <u>SILVER SPRING</u> (County) <u>MONTGOMERY</u> (State) <u>MD</u>   |  |   |  |   |  |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Belden R. Neap</u>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |  |  |
| EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>   |  |   |  | M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |  |  |
|   |  |   |  | 22. DATE SIGNED <u>DEC. 21, 1967</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>12/23/1967</u>             |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>                                   |  |  |  |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>  |  |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |   |  |   |  |   |  |  |  |

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*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. Some words like "New York" and "Albany" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b><br>c. LENGTH OF STAY IN 1b <b>3 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>         |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLCOTT CITY</b><br>d. STREET ADDRESS <b>RT. 2</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VIOLA</b> Middle <b>RACHEL</b> Last <b>SELBY</b>  |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>2</b> Year <b>19 67</b>   |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>6-16-01</b>  |
| 9. AGE (In years lost birthday) <b>66</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>ZETTA EASTON</b>   |  | 14. MOTHER'S MAIDEN NAME <b>MINNIE MUSGROVE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>  |  | 16. SOCIAL SECURITY NO. <b>217-34-5282</b>   |  |
| 17. INFORMANT <b>MEDICAL RECORDS</b>  |  | Address <b>MONT. GEN. HOSP. OLNEY MD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5870</b><br>DUE TO <b>TOXEMIA - SEPTISEMIA</b><br>(b) <b>PAUCREATIC ABSCESS</b><br>DUE TO <b>PANCREATITIS, NECROTIC</b><br>(c) <b>INFARCTION TERMINAL LEUM - DUE TO ADHESIONS</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b><br><b>WKS -</b><br><b>8-12 WKS</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 1967</b> to <b>DEC 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>DEC 2, 1967</b> , and that death occurred at <b>8:45 A.M.</b> from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <b>Donald F. Jones</b>   |  | 22b. DATE SIGNED <b>DEC 2, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 23b. DATE THEREOF <b>12-5-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>GRISTLAWN</b>  | 23d. LOCATION (City or Town) (County) (State) <b>N. FRIENDSHIP MD.</b> |
| 24. FUNERAL DIRECTOR <b>Highman - Synek</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

|   |   |  |   |
|---|---|--|---|
| 17357   |   | 17357  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u> 15.1   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Corroll Hall Sanatorium.</u>   |   | d. STREET ADDRESS <u>CARROLL HALL SANITARIUM</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Frances</u> Middle <u>A.</u> Last <u>Shaffer</u>  |   | 4. DATE OF DEATH<br>Month <u>DECEMBER</u> Day <u>22</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 7, 1874</u>   |
| 9. AGE (In years last birthday)<br><u>93</u> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>CLEVELAND OHIO</u>                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 13. FATHER'S NAME<br><u>JAY P. PAWLEY</u>  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>IVA GISSELA CAMPBELL</u>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>                            |   |
| 16. SOCIAL SECURITY NO.<br><u>286-24-6832D</u>  |   | 17. INFORMANT<br><u>Col. Henry L. Shaffer - WASH. D.C.</u> Address <u>5454 Motion Rd.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br>4201<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,<br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO<br>(c) <u>GENERALIZED ARTERIOSCLEROSIS</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 MINUTES</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>SEWILITY</u>  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> , 19 <u>67</u> , to <u>DEC. 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC. 22</u> , 19 <u>67</u> , and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE<br><u>Henry M. Lowden</u>  |   | 22b. DATE SIGNED<br><u>12/23/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Henry M. Lowden</u>  |   | 22d. ADDRESS<br><u>5206 Norway Dr., Kensington, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>CREMATION</u>   | 23b. DATE THEREOF<br><u>12/23/1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Crematory Calmar Marine Pk 666 MD</u>  | 23d. LOCATION (City, town or county) (State)<br><u>Kensington, Md.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>W.W. CHAMBERS Co - Washington, D.C.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 29 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |   |  |   |  |  |  |   |  |
|---|--|----------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Rocky Hill</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |                                  |  | c. LENGTH OF STAY IN 1b<br><u>48 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rocky Hill Connellville</u>                                |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>  |  |                                  |  |   |  | d. STREET ADDRESS<br><u>122 Sycamore Street</u>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SARA</u> Middle <u>A.</u> Last <u>Shartzee</u>  |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>6</u> Year <u>19 67</u>  |  |  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>10-5-95</u>  |  | 9. AGE (In years lost birthday)<br><u>72</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>Issac Morgan</u>  |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ida May Docherty</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |                                  |  | 16. SOCIAL SECURITY NO.<br><u>182-36-3908</u>   |  | 17. INFORMANT<br><u>Mrs. John E. Grubb</u> 705 W. <u>Winhall Way</u> <u>Silver Spring, Md.</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>334 X</u> <u>CEREBRAL ARTERIAL SCLEROSIS</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>7-2</u> DUE TO<br>(c) <u></u> DUE TO |  |                                  |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                                  |  |   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)               |  |   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Oct 19</u> , 19 <u>67</u> , to <u>Dec 6</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>Dec 6</u> , 19 <u>67</u> , and that death occurred at <u>2:35 P</u> M, from causes and on the date stated above.  |  |                                  |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Jonathan M. Williams</u>   |  |                                  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22b. DATE SIGNED<br><u>Dec-6-67</u>                |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Jonathan M. Williams</u>   |  |                                  |  |   |  | 22d. ADDRESS<br><u>808 Pershing Dr. Silver Spring</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State)      |  |   |  |
| <u>Trans-burial</u>   |  | <u>Dec. 8, 1967</u>              |  | <u>Greensridge Memorial Park</u>  |  |   |  | <u>Connellville, Penna.</u>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>C. Glen Carter</u> 434 <u>Georgia Avenue</u><br><u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>  |  |                                  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 11 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |   |  |

11382

CERTIFICATE OF DEATH

11384

Jonathan M. Williams - 808 Pershing St. New York  
Dec 11 1961  
Dec 11 1961  
Dec 11 1961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

17359

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17359

|   |                                  |   |                                    |  |   |  |                                |
|---|----------------------------------|---|------------------------------------|--|---|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |  |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring, Md.</b>   |                                  | c. LENGTH OF STAY in lb<br><b>7 Days</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>   |   |  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Holy Cross Hospital</b>  |                                  |   |                                    | d. STREET ADDRESS<br><b>4207 East West Highway</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>J.</b> Last <b>Sheffer</b>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>6</b> Year <b>1967</b>  |   |  |                                |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/12/90</b> | 9. AGE (In years last birthday)<br><b>77 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>C. P. A.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>self employed</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Wisconsin</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |                                |
| 13. FATHER'S NAME<br><b>Eddy Sheffer</b>  |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Myrtie Maxon</b>  |   |  |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service)<br><b>yes W W I</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>577-40-6850</b>   |                                    | 17. INFORMANT Address<br><b>Charlotte M. Sheffer Hyattsville, Md.</b>  |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute massive intracerebral hemorrhage</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH   |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)  |                                    |  |   |  |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                    |  |   |  |                                |
| ACTUAL SIGNATURE<br><b>Belden R. Reap</b>   |                                  | M.D.  |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>DEC. 6 1967</b>  |                                |
| EXAMINER'S NAME (Type)<br><b>BELDEN R. REAP M.D.</b>  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                    | Address, (City or town, county, state)   |   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Dec 9, 1967</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>               |                                |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>F. Gasch's Sons Hyattsville, Md.</b>   |                                  |   |                                    | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 11 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |  |   |  |  |   |  |
|---|--|---|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |   |  |   |  |  |   |  |
| 17360   |  |   |   |  |   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |  |   | c. LENGTH OF STAY IN TB<br><u>YEARS</u>       |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>   |  |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>3907 Warner St.</u>  |  |   |   |  | d. STREET ADDRESS<br><u>3907 Warner St.</u>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Helen D Sheldon</u>   |  |   |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>30</u> Year <u>1967</u>  |  |  |   |  |
| 5. SEX<br><u>F</u>  |  | 6. COLOR OR RACE<br><u>W</u>                  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 8. DATE OF BIRTH<br><u>12/6/05</u>                                     |  | 9. AGE (In years last birthday)<br><u>62</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Queens County, N.Y.</u>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                |   |  |
| 13. FATHER'S NAME<br><u>James G. DeBevoise</u>  |  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Mac Hardy</u>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |   | 16. SOCIAL SECURITY NO.<br><u>216-46-2918</u> |  | 17. INFORMANT<br>Address <u>Husband - James Sheldon</u>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the</u><br><u>1939</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Oligo blastoma</u><br>DUE TO (c) <u>—</u> |  |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>   |  |   |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)<br><u>None</u>  |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>—</u> o.m. <u>None</u> 19 p.m. <u>19</u>  |  |   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/15, 1967</u> to <u>present</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/29/1967</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.  |  |   |   |  |   |  |  |   |  |
| 22a. SIGNATURE<br><u>John B. Umhau</u>  |  |   |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED<br><u>12/30/67</u>  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN B. UMHAY MD</u>   |  |   |   |  | 22d. ADDRESS<br><u>8805 Conn. Ave. Chevy Chase Md</u>   |  |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition<br><u>BURIAL</u>   |  | 23b. DATE THEREOF<br><u>4 Jan 1968</u>        |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Rockville Mont Md.</u> |   |  |
| 24. FUNERAL DIRECTOR<br><u>Robert A Pumphrey</u>  |  |   |   |  | ADDRESS<br><u>7557 Wisconsin Ave Bethesda, Md</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 5 1968</u>                          |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |

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BUREAU OF THE  
LAND OFFICE  
WASHINGTON, D. C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>R. Boyds</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>(R) Boyds-</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Box 17 B-</u>   |                               | d. STREET ADDRESS<br><u>Box 17. B.</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>William Arthur Shiflet</u>   |                               | 4. DATE OF DEATH<br>Month <u>Dec-</u> Day <u>8</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M.</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 7, 1913</u> |
| 9. AGE (In years last birthday)<br><u>54</u> yrs.  |                               | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Gen'l. Engineer</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Ohio</u>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |  |
| 13. FATHER'S NAME<br><u>Elisah Shiflet</u>   |                               | 14. MOTHER'S MAIDEN NAME<br><u>Virginia Fowler</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>884-07-6346</u>   |  |
| 17. INFORMANT<br><u>Mrs. Margaret Simpson Shiflet, Boyds, Md.</u>  |                               | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>  </u><br>DUE TO<br>(c) <u>  </u>  |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |  |
| ACTUAL SIGNATURE<br><u>John E. Ball</u>  |                               | 22. DATE SIGNED<br><u>12/9/67</u>   |  |
| EXAMINER'S NAME (Type)   |                               | Address (Street, city, town, or county)   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 23b. DATE THEREOF<br><u>13 Dec. 67</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Comfort Cemetery</u>  |                               | 23d. LOCATION (City or Town) (County) (State)<br><u>Fairfax Co., Virginia</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>B. Earle Mountcastle</u>  |                               | 25a. REC'D BY REGISTRAR<br><u>DEC 13 1967</u>   |  |
| Cunningham-Mountcastle Funeral Home, Woodbridge, Va.   |                               | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MONTGOMERY STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |  |   |   |                                  |
|---|--|---|--|---|---|--|---|---|----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |  |   |   |                                  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |   |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u> |  |   |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chester</u>  |  |   | c. LENGTH OF STAY IN 1b<br><u>1 yr. 4 mo</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring, Maryland</u> <u>15.1</u>      |  |   |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>University Nursing Home</u>  |  |   |  |   | d. STREET ADDRESS<br><u>5 Burkett Court</u>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Jesse</u> Middle <u>Ashby</u> Last <u>Shives</u>   |  |   |  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>22</u> Year <u>1967</u>  |  |   |   |                                  |
| 5. SEX<br><u>♂</u>  |  | 6. COLOR OR RACE<br><u>W</u>                            |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>2-26-1879</u>                                   |   | 9. AGE (In years last birthday)<br><u>88</u> yrs.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Gas Station Owner</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Gas Station</u> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Hancock, Md.</u>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Amer</u>                               |   |                                  |
| 13. FATHER'S NAME<br><u>Unknown</u>   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |   |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  |   | 16. SOCIAL SECURITY NO.<br><u>579-20-8539A</u> |   | 17. INFORMANT<br><u>Dorothy Garner</u> Address <u>5 Burkett Court Silver Spring, Md.</u>  |  |   |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>481X Flu Syndrome - General Debility</u><br>DUE TO (b) <u>Ac Crd.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> |  |   |  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. _____ p.m. _____ 19 _____   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Dec 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 18</u> , 19 <u>67</u> , and that death occurred at <u>11:30P</u> M, from causes and on the date stated above.  |  |   |  |   |   |  |   |   |                                  |
| 22a. SIGNATURE<br><u>Russell C. Bufalino</u>  |  |   |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>     |  | 22b. DATE SIGNED<br><u>Dec 22, 1967</u>                                   |   |                                  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Russell C. Bufalino</u>  |  |   |  |   | 22d. ADDRESS<br><u>1429 University Blvd W.</u>  |  |   |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>Dec. 27, 1967</u>               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glenwood Cemetery</u>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u> |   |                                  |
| 24. FUNERAL DIRECTOR<br><u>John B. Thomas</u><br><u>Warner E. Pukshrey, Inc.</u>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 28 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John B. Thomas</u>                       |   |                                  |

13382

13382

CENTRAL AIRCRAFT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 File # 3396 1/5/68

CERTIFICATE OF DEATH

17363

17363

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>WASH.</u>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Kensington Gardens Sanitarium</u>   |                                  | d. STREET ADDRESS<br><u>Route # 2</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>MARTHA JANE SHIVES</u>   |                                  | 4. DATE OF DEATH<br>Month <u>DEC.</u> Day <u>14</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>2.11.1879</u>           |
| 9. AGE (In years last birthday)<br><u>86</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months _____ Days _____   | 11. IF UNDER 24 HRS.<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>WASHINGTON COUNTY MD.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>ELIZABETH BAKER</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes: give war or dates of service)<br><u>NO</u>   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><u>MRS LEO YOUNKER RURAL 2 HANCOCK MD.</u>  |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>491X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u><br>DUE TO (c) <u>Advanced senility</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u><br><u>1 yr.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. _____ p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>67</u> to <u>Dec 14</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>Dec 14</u> 19 <u>67</u> , and that death occurred at <u>10P</u> M, from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><u>Marvin Wadler</u>   |                                  | 22b. DATE SIGNED<br><u>12/14/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MARVIN WADLER</u>   |                                  | 22d. ADDRESS<br><u>8218 Wisc. Av. Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 23b. DATE THEREOF<br><u>12.17.67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>ORCHARD RIDGE</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>RURAL HANCOCK WASHINGTON MD</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Howard H. Stone Hagerstown md</u>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 20 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                  |  |  |

13368

13368

CENTRAL DISTRICT

2.11.1999

WASHINGTON COUNTY MD. D.C.A.

ELIZABETH BAKER

MARY L. YOUNG - JUDGE

NO. 13368

WASHINGTON COUNTY, MARYLAND

CLERK OF THE COURT

13.11.99

13368

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17364

CERTIFICATE OF DEATH

17364

|  |                                  |   |                         |  |  |   |   |
|--|----------------------------------|---|-------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  |   |                         | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>   |                                  |   | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Falls Church</u>                              |  |   | 2312  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>University Nursing Home</u>   |                                  |   |                         | d. STREET ADDRESS<br><u>6030 Vista Drive</u>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Arthur James Shugars</u>  |                                  |   |                         | 4. DATE OF DEATH<br>Month Day Year<br><u>December 3 19 67</u>  |  |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Caus.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | B. DATE OF BIRTH<br><u>1/22/1889</u>   |  | 9. AGE (In years last birthday) yrs.<br><u>78</u>                         |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chief Engineer</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                         | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Louden County, Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                |   |
| 13. FATHER'S NAME<br><u>James Shugars</u>  |                                  |   |                         | 14. MOTHER'S MAIDEN NAME<br><u>Cassandrew Stoneburner</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes World War I</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>577-10-0399</u>   |                         | 17. INFORMANT<br>Address<br><u>Delia H. Shugars</u>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cerebrovascular disease 6 mo =</u><br>DUE TO (c) |                                  |   |                         |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>45 min</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                         |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                         |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>OCT 11, 1967</u> to <u>DEC 3, 1967</u> that (I) (we) last saw the deceased alive on <u>3 DEC 1967</u> , and that death occurred at <u>3:45 P</u> M, from causes and on the date stated above.   |                                  |   |                         |  |  |   |   |
| 22a. SIGNATURE<br><u>Walter G. Goorh</u>   |                                  |   |                         | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>      |  | 22b. DATE SIGNED<br><u>12/3/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>WALTER GOORH MD</u>  |                                  |   |                         | 22d. ADDRESS<br><u>2304 SHOREFIELD RD WHEATON MD</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE THEREOF<br><u>Dec. 6. 1967</u>  |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Culpeper National</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Culpeper Virginia</u> |   |
| 24. FUNERAL DIRECTOR<br><u>Jackie L. Buggs - see funeral home</u>  |                                  |   |                         | 25a. REC'D BY REGISTRAR<br><u>DEC 7 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                        |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17364

RECEIVED BY DEATH

17364

DEC 1 1963

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. LENGTH OF STAY IN 1b <u>DOA</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>   |  | d. STREET ADDRESS <u>734 College Pkwy</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Brian</u> First <u>Michael</u> Middle <u>Shulman</u> Last   |  | <b>4. DATE OF DEATH</b><br><u>Dec 22</u> 19 <u>67</u>  |  |
| 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH <u>Nov 26 1966</u>  |  | 9. AGE (In years lost birthday) yrs. <u>1</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Mayford</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Barry Shulman</u>   |  | 14. MOTHER'S MARDEN NAME <u>Myrna Harrison</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 17. INFORMANT <u>Mathw - Same as above.</u> Address  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>AsPhyxia</u><br>DUE TO<br>(b) <u>ASPIRATION. of Food.</u><br>DUE TO<br>(c) |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>   |  | 20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aspirated piece of apple. he was eating.</u>   |  |
| 22c. TIME OF INJURY Month, Day, Year<br><u>10</u> <u>pm</u> <u>12/22</u> 19 <u>67</u>  |  | 22d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  |  |
| 23e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home.</u>  |  | 23f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md</u>  |  |
| 24. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>John S. Ball</u> EXAMINER'S NAME (Type)  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/22/67.</u>                               |  |
| 25a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 25b. DATE THEREOF <u>12/24/67</u>  |  |
| 25c. NAME OF CEMETERY OR CREMATORY <u>ADATH ISRAEL CEM.</u>  |  | 25d. LOCATION (City or Town) <u>IRENTON N.J.</u> (County) (State)  |  |
| 25e. FUNERAL DIRECTOR <u>Goodley Funeral Home 4217-9th Ave.</u> ADDRESS  |  | 25f. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |

1955

STATE OF CALIFORNIA

1955

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17366

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 6 & 7 Film G396 1/3/68 KK  
CERTIFICATE OF DEATH

17366

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                                      | c. LENGTH OF STAY IN 1b<br><u>1yr 3 mos.</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>  |                                      | d. STREET ADDRESS<br><u>9906 East Bexhill Drive</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bethesda-Silver Spring Nursing Home</u>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Edith</u> Middle <u>Sibert</u> Last <u>Sibert</u>   |                                      | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>21</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>Jan 30, 1896</u> |
| 9. AGE (In years lost birthday)<br><u>71</u> yrs.  |                                      | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>- - - -</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>West Virginia</u>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Van Shelby Perkins</u>   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Frances Williams</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                      | 16. SOCIAL SECURITY NO.<br><u>403-01-8586 D</u>  |   |
| 17. INFORMANT<br><u>Boyd Sibert - See Item No. 2</u>   |                                      | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u><br>DUE TO<br>(b) <u>Cerebral Artery Sclerosis</u><br>DUE TO<br>(c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>years</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>62</u> , to <u>Dec 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 15</u> 19 <u>67</u> , and that death occurred at <u>2<sup>00</sup></u> P.M., from causes and on the date stated above.                                    |                                      |  |   |
| 22a. SIGNATURE<br><u>Robert B. Harell</u>  |                                      | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert B. Harell MD</u>   |                                      | 22d. ADDRESS<br><u>5516 Nebraska Ave DC</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                      | 23b. DATE THEREOF<br><u>12-26-1967</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington Natl. Cemetery</u>  |                                      | 23d. LOCATION (City or Town) (County) (State)<br><u>Arlington, Va.</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons, Inc.</u>  |                                      | 25a. REC'D BY REGISTRAR<br><u>DEC 28 1967</u>  |   |
| ADDRESS<br><u>5130 Wisc. Ave. N.W.</u><br><u>Wash. D.C.</u>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |  |   |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                              |  |  |  |   |  |  |  |   |  |
| Item #2a,b,c & d Film#G396 32120772  |  |                              |  |  |  |   |  |  |  |   |  |
| 17367  |  |                              |  |  |  |   |  |  |  |   |  |
| Item #23b Film #3396 32120772  |  |                              |  |  |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |                              |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING MD</u>  |  |                              |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u> 15.1                       |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>DELLA VISTA NURSING HOME</u>  |  |                              |  |  |  | d. STREET ADDRESS<br><u>10430 Brookmore Drive</u>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><u>RILLA MAE HAUKE SKINNER</u>  |  |                              |  |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>6</u> Year <u>1967</u>   |  |  |  |   |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>W</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><u>Sept 10, 1889</u>  |  | 9. AGE (In years last birthday)<br><u>78</u> yrs.                      |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>General Serv - Blind</u>   |  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>General Serv</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Jacoma, Washington</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                                      |  |
| 13. FATHER'S NAME<br><u>Charles Hauke</u>  |  |                              |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Carrie Duncan</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                              |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>MRS. HOMI SULLIVAN</u> Address <u>10430 Brookmore Dr. S.S. MD.</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>442X</u> DUE TO (b) <u>Cardio-Vascular Renal Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs</u><br><u>1 Yr.</u> |  |                              |  |  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                              |  |  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |  |                              |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> , 19 <u>67</u> , to <u>12/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>67</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.  |  |                              |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Harold Heiges</u>   |  |                              |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>     |  | 22b. DATE SIGNED<br><u>12/6/67</u>                                     |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Harold Heiges</u>   |  |                              |  |  |  | 22d. ADDRESS<br><u>5415 Con Ave NW DC</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>  </u>   |  |                              |  | 23b. DATE THEREOF<br><u>Dec 8, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Washington D.C.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Arthur Walters</u>  |  |                              |  |  |  | 25a. REC'D BY REGISTRAR<br><u>  </u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                     |  |   |  |
| DATE <u>DEC 11 1967</u>  |  |                              |  |  |  |   |  |  |  |   |  |



17368  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17368

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>PR. GEO</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  | c. LENGTH OF STAY IN 1b<br><b>56 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Frank Kane SLASON</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 31 19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 22, 1913</b>                                     |
| 9. AGE (In years last birthday) yrs.<br><b>54</b>   |  | 10. IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Capt. USN</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Staten Island, New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John A. Slason</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Kane</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO.<br><b>561 54 3644</b>   |   |
| 17. INFORMANT <b>Apt. 409, Chevy Chase, Md.</b>   |  | <b>Miss Helen B. Schumann, 5100 Dorset Ave.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br><b>5810</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>Nov. 5</b> , 19 <b>67</b> , to <b>Dec. 31</b> , 19 <b>67</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>Dec. 31</b> , 19 <b>67</b> , and that death occurred <b>1145A</b> M, from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Frank C. Blackburn</b>   |  | 22b. DATE SIGNED<br><b>Jan. 2, 1968</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank C. Blackburn, M. D.</b>  |  | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/4/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Virginia</b> |
| 24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b><br><b>1102 W. Broad St., Falls Church, Virginia</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 8 1968</b><br>25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17369

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|  |                              |   |  |   |   |   |  |
|--|------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>MONTGOMERY</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u>  |                              |   | c. LENGTH OF STAY IN 1b<br><u>97 days (12-11-67)</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA</u> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>  |                              |   |  | d. STREET ADDRESS<br><u>4512 HARLING LANE</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>MAE</u> Middle <u>JORIE</u> Last <u>SLOTHOWER</u>   |                              |   |  | 4. DATE OF DEATH<br>Month <u>DEC</u> Day <u>11</u> Year <u>1967</u>   |   |   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-28-99</u>   |   | 9. AGE (In years last birthday)<br><u>68</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>James Turck</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/No or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>577-54-2634</u>   |  | 17. INFORMANT<br><u>Son - John H. Slothower</u> Address <u>Same as Item 2.</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis with intestinal obstruction</u><br>DUE TO (b) <u>Primary carcinoma of ovary</u><br>DUE TO (c) <u>1750</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                              |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u><br><u>12 months</u>                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>56</u> , to <u>DEC</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 10</u> 19 <u>67</u> , and that death occurred at <u>4:00</u> M, from causes and on the date stated above.   |                              |   |  |   |   |   |  |
| 22a. SIGNATURE<br><u>[Signature]</u>   |                              |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |   | 22b. DATE SIGNED<br><u>12/11/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DR LEO I DONOVAN</u>  |                              |   |  | 22d. ADDRESS<br><u>8218 WILSON AVE</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>12-14-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Warrington Quaker Cem.</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Wellsville, Penna.</u>                        |  |
| 24. FUNERAL DIRECTOR<br><u>Robert A. Pumphrey, Bethesda, Maryland</u>  |                              |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

13382

13382

Montgomery  
Barnes  
4212 Maryland Ave  
Barnes  
Montgomery

Mr. J. W. F.  
6-22-27

James F. F.  
6-22-27

James F. F.  
6-22-27

James F. F.  
6-22-27

James F. F.  
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James F. F.  
6-22-27

James F. F.  
6-22-27

James F. F.  
6-22-27

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Cleared by Dr. Beldon Korp

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17370

CERTIFICATE OF DEATH

\*Also known as

EVA ELORA SCHMITZ.

17370

|   |                              |   |                                      |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>                    |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>36 Days</u>   |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING TAKOMA PARK</u>  |                              | d. STREET ADDRESS <u>903 JACKSON AVE</u><br><u>2700 PARKER ST</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SYLVAN MAJOR HEALTH CARE CENTER</u>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>EVA</u> Middle <u>ELORA</u> Last <u>SMITH*</u>   |                              | 4. DATE OF DEATH<br>Month <u>DEC.</u> Day <u>16</u> Year <u>1967</u>  |                                      |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/10/1872</u> |
| 9. AGE (In years last birthday)<br><u>95</u> yrs.   |                              | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at Home</u>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME<br><u>Butler</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>Not available</u>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>  </u>  |                                      |
| 17. INFORMANT<br><u>Frank C. Kuge (same as #2)</u>  |                              | Address<br><u>  </u>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis is Generalized</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>  </u>  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)<br><u>  </u>   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |                              | 20f. (City or town) (County) (State)<br><u>  </u>   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>38</u> , to <u>2-16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.   |                              |   |                                      |
| 22a. SIGNATURE<br><u>Arthur H. Kates</u> M.D.   |                              | 22b. DATE SIGNED<br><u>12-16-67</u>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Arthur H. Kates</u>  |                              | 22d. ADDRESS<br><u>2717 Carroll Ave Takoma Park</u>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE THEREOF<br><u>Dec. 19, 1967</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Evergreen Memorial Park</u>  |                              | 23d. LOCATION (City or town) (County) (State)<br><u>Portsmouth Va</u>   |                                      |
| 24. FUNERAL DIRECTOR<br><u>Arthur H. Kates</u>  |                              | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                              | DATE<br><u>DEC 21 1967</u>  |                                      |

1992

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17371

17371

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |  |   |   |   |  |
|--|--|---|--|---|--|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |  |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |   | c. LENGTH OF STAY IN 1b<br><u>8 days</u>   |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u> |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hospital</u>   |  |   |  | d. STREET ADDRESS<br><u>4311 Independence St</u>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>MADeline</u> First <u>E.</u> Middle <u>Smith</u> Last  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>11</u> Year <u>1967</u>  |  |  |   |   |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11/26/1898</u>  |   | 9. AGE (In years last birthday) yrs. <u>69</u>        |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Government Emp.</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY             |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Penna</u>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |   |  |
| 13. FATHER'S NAME<br><u>William B. Rudy</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Alvaritta Smith</u>  |  |  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.<br><u>579-12-6893</u> |  | 17. INFORMANT<br><u>daughter Arline Smith</u>   |  |  | Address <u>Same as above</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hypostatic bronchopneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/3/67</u> , 19 <u>67</u> , to <u>12/11/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/11/67</u> , 19 <u>67</u> , and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above.  |  |   |  |   |  |  |   |   |   |  |
| 22a. SIGNATURE<br><u>Jay R. Shapiro</u>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><u>12/11/67</u>  |   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>J. R. Shapiro</u>   |  |   |  | 22d. ADDRESS<br><u>8218 Wisconsin Ave, Bethesda, Md.</u>  |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL, etc.<br><u>Burial-Transit</u>   |  | 23b. DATE THEREOF<br><u>12/13/67</u>          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mafflinburg</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Mifflinburg, Pa.</u>                          |   |   |  |
| 24. FUNERAL DIRECTOR<br><u>Tyson Wheeler</u>   |  |   |  | 1331 Rockville Pike<br>Rockville, Maryland  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u> |   |  |

17371

17371

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Government Rep.

Supervisor

State of Wisconsin, Department of Social Services

U. S. Bureau

U. S. Department of Health, Education and Welfare

Division of Health Services, Bureau of Health Statistics

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  | c. LENGTH OF STAY IN TB<br><b>4 DAYS</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>HOLY CROSS HOSP.</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OLIVER</b> Middle <b>James</b> Last <b>SMITH</b>  |  | 4. DATE OF DEATH<br>Month <b>DEC</b> Day <b>27</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/1/95</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Agent</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Internal Revenue</b>  | 9. AGE (In years last birthday) yrs. <b>72</b>   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Kentucky</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Major D. Smith</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Singelton</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>215-38-4449 A</b>   |  |
| 17. INFORMANT<br><b>Eva M. Smith</b>  |  | Address <b>9405 Avenel Road Silver Spring, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cerebral vascular accident</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>Several years</b>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour "a.m." p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>December 23, 1967</b> , to <b>December 27, 1967</b> , that (I) (we) lost the deceased alive on <b>December 26, 1967</b> , and that death occurred at <b>3:30 A.M.</b> , from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>Bennet A. Porter, Jr.</b>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        | 22b. DATE SIGNED<br><b>December 27, 1967</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Bennet A. Porter, Jr. M.D.</b>   |  | 22d. ADDRESS<br><b>9301 Coleridge Rd., Silver Spring, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Dec. 28, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince Georges Co. Md.</b>                 |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Humphrey, Inc. Silver Spring, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 4 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

STATEMENT OF WORK

1. The purpose of this statement is to define the work to be done by the contractor under the contract.

2. The work to be done is to design and construct a bridge over the river at the location shown on the map.

3. The bridge is to be a steel truss bridge with a span of 100 feet.

4. The bridge is to be constructed of steel and concrete.

5. The bridge is to be designed to carry a load of 100 tons.

6. The bridge is to be constructed in accordance with the specifications of the American Institute of Steel Construction, Inc.

7. The bridge is to be constructed in accordance with the specifications of the Federal Highway Administration.

8. The bridge is to be constructed in accordance with the specifications of the State of Maryland.

9. The bridge is to be constructed in accordance with the specifications of the local authorities.

10. The bridge is to be constructed in accordance with the specifications of the contractor.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b <u>D+A</u>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blen Echo</u> 15-1 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard Hospital</u>  |   | d. STREET ADDRESS <u>6103 Princeton Ave</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>Smith</u>   |   | 4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1967</u>  |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Aug 11, 1909</u> 58  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Robert Edward Smith Dr.</u>   |   | 14. MOTHER'S MAIDEN NAME <u>?</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>579-03-5133</u>  |  |
| 17. INFORMANT Address <u>add same</u><br><u>Catherine E. Smith - wife</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4201</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)        |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u>                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE <u>John G. Ball</u><br>EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>Bethesda, Md.</u>              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>12-20-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |   | 25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                |

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REPORT OF THE SURVEYOR

1954-1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17374  
CERTIFICATE OF DEATH

|   |  |  |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b> |  | c. LENGTH OF STAY IN lb<br><b>11 months</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Montgomery</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b> |  | d. STREET ADDRESS<br><b>15-1<br/>37 Philadelphia Ave., Takoma Park</b>        |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>ANNIE</b>   |  | First  |  | Middle<br><b>GOLDEN</b>   |  | Last<br><b>SPRINGMANN</b>  |  | 4. DATE OF DEATH<br><b>Dec. 22 1967</b>  |  | Month  |  | Day   |  | Year  |  |  |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-12-85</b>   |  | 9. AGE (In years last birthday)<br><b>82</b> yrs.  |  | IF FUNERAL 1 YEAR  |  | IF FUNERAL 24 HRS.  |  | Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE MD</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                     |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>CHARLES REANEY</b>  |  |  |  |   |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>218-56-8935-7</b>   |  |  |  | 17. INFORMANT<br><b>Nursing Home Records</b>   |  |  |  | Address   |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |  |   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>17 YEARS</b>          |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)  |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 1960, to <b>Dec</b> , 1962, that (I) (we) last saw the deceased alive on <b>12-15</b> 1962, and that death occurred at <b>M</b> , from the causes and on the date stated above.  |  |  |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Harry R. Wolf</b>  |  |  |  |   |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22b. DATE SIGNED<br><b>12/22/1967</b>   |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>H. R. WOLF</b>   |  |  |  |   |  |  |  | 22d. ADDRESS<br><b>905 Shandon St Hyattsville</b>  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE THEREOF<br><b>Dec 26, 1967</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Southland Baltimore Md</b> |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur Walters</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>Washington, D.C.</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  | DATE<br><b>DEC 27 1967</b>  |  |   |  |  |  |

255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 17375  |   | 17376   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   | c. LENGTH OF STAY IN lb<br><u>30 yrs</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1908 CLEGGLE AVENUE</u>   |   | d. STREET ADDRESS<br><u>1908 Glen Allen Pk. E.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Paul</u> First <u>Stadler</u> Middle Last  |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>4</u> Year <u>1967</u>   |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 28 1898</u>   |
| 9. AGE (In years last birthday) <u>69</u> yrs.   |   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self-employed</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Winery</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Switzerland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |   |
| 13. FATHER'S NAME<br><u>Henrich Stadler</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Bertha Eichenberger</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>578-46-6967</u>   |   |
| 17. INFORMANT<br><u>Mrs. R. Skater</u>   |   | Address<br><u>1908 Glen Allen S.E. Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>177X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Edenolacarcinoma Prostatic Glandularis</u><br>(c) <u>Bladder Stenosis</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2/15/67</u><br><u>1st known</u>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (o)<br><u>Tumor growth under also Pelvis + at Hip area</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/15/1966</u> , to <u>12/4/1967</u> , that (I) (we) last saw the deceased alive on <u>11/28/1967</u> , and that death occurred at <u>130</u> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>Howard T. Morse</u>   |   | 22b. DATE SIGNED<br><u>12/4/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Howard T. Morse</u>   |   | 22d. ADDRESS<br><u>7630 Arnette Rd. Takoma Park Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Dec. 6, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Union Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>McConellsburg, Penna.</u>                     |
| 24. FUNERAL DIRECTOR<br><u>C. Glen Carter</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 7 1967</u>  |   |
| ADDRESS<br><u>434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

11372

EXHIBIT 11

11372



RECEIVED  
JAN 11 1961  
FBI - NEW YORK  
100-11372

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17376

17377

|   |                              |   |                                     |  |   |  |   |
|---|------------------------------|---|-------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                              |   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |                              |   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>                                 |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>  |                              |   |                                     | d. STREET ADDRESS<br><u>9706 Pisgah Rd. MT.</u>  |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>DORAN</u> Middle <u>(NMI)</u> Last <u>STARKEY</u>   |                              |   |                                     | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>8</u> Year <u>1967</u>  |   |  |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-31-21</u> |  | 9. AGE (In years last birthday)<br><u>46</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.          |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CLASSIFIED</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>DEPT. DEFENSE</u>   |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Penna.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>         |   |
| 13. FATHER'S NAME<br><u>GEORGE B. STARKEY</u>   |                              |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>HELEN PHILLIPS</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>WWII AND KOREAN 163-18-2438</u>   |                                     | 17. INFORMANT<br><u>PETER EDIVAN 2463 COOL SPRING RD, ADELPHI MD.</u>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE (STROKE)</u><br><u>+201</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CORONARY THROMBOSIS-MYOCARDIAL INFARCTION</u><br>DUE TO<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> |                              |   |                                     |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10-11 HOURS</u><br><u>CIRCA 5-6 YEARS</u>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS</u>  |                              |   |                                     |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> <u>19</u> p.m.   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)               |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov., 1966</u> , to <u>12/8, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/8, 1967</u> , and that death occurred at <u>1:35</u> M, from causes and on the date stated above.   |                              |   |                                     |  |   |  |   |
| 22a. SIGNATURE<br><u>Lawrence D. Marcus</u>   |                              |   |                                     | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |   | 22b. DATE SIGNED                                   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>LAWRENCE D. MARCUS, MD.</u>  |                              |   |                                     | 22d. ADDRESS<br><u>1111 SPRING STREET, SILVER SPRING, MD.</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE THEREOF   |                                     | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or town) (County) (State)      |   |
| <u>RURAL</u>  |                              | <u>11 DEC. 1967</u>   |                                     | <u>GERMAN LUTHERAN CEMETERY</u>  |   | <u>MAHANOCY CITY PA.</u>                           |   |
| 24. FUNERAL DIRECTOR<br><u>RINALDI FUNERAL HOME, 7400 GEORGIA AVE. NW, DC 20012</u>   |                              |   |                                     | 25a. REC'D BY REGISTRAR<br><u>DEC 11 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13276

Free riding  
for some hours

1950

13276

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

17377 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 Film #G397 1/24/68 ar

CERTIFICATE OF DEATH

17378

|   |                           |   |                                       |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>MONTGOMERY</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>M.D.</b> D. C. b. COUNTY <b>MONTGOMERY</b>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b> Washington   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sylvan Manor Health Care Center</b>  |                           | d. STREET ADDRESS <b>1028 Conn. Ave. NW</b><br><b>Stoneleigh Apts</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BLANCHE</b> Middle <b>W.</b> Last <b>STEEVER</b>  |                           | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>31</b> Year <b>1967</b>  |                                       |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-28-1882</b> |
| 9. AGE (In years lost birthday) Yrs. <b>85</b>  |                           | IF UNDER 1 YEAR Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>N/A</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Alonzo M. L.</b>  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Jennie (Maiden name unknown)</b>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                           | 16. SOCIAL SECURITY NO.<br><b>325-09-3705</b>   |                                       |
| 17. INFORMANT<br><b>Watson Andrews</b>  |                           | Address   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b><br><b>1538</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>RECENT FEBRILE RESPIRATORY DISEASE</b>  |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> to <b>DEC 31</b> , 1967, that (I) (we) last saw the deceased alive on <b>DEC 31</b> , 1967, and that death occurred at <b>2:40 PM</b> , from causes and on the date stated above.                                     |                           |   |                                       |
| 22a. SIGNATURE<br><b>Edward A. Beeman</b> M.D.  |                           | 22b. DATE SIGNED<br><b>DEC 31, 1967</b>   |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EDWARD A. BEEMAN</b>   |                           | 22d. ADDRESS<br><b>1015 SPRING ST. SILVER SPRING, MD.</b>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                           | 23b. DATE THEREOF<br><b>Jan 5, 1968</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Grove Cemetery</b>  |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Cincinnati, Ohio</b>  |                                       |
| 24. FUNERAL DIRECTOR<br><b>Murphy Funeral Home</b>  |                           | 25a. REC'D BY REGISTRAR<br><b>JAN 8 1968</b>  |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                           |   |                                       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)  
25M 1/1-7

| <div style="display: flex; justify-content: space-between;"> <span>17378</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>Item 4 Film G396 1/12/68</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div> <span>17379</span> |      |   |  |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
|---|------|---|--|---|--|---|--|---|--|-----------------|--|------------------|--|--------|------|-------|------|--|--|-----------|----------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>MONTGOMERY</b> MARYLAND  |      |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>  |      |   | c. LENGTH OF STAY IN lb<br><b>10 HR.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GAITHERSBURG</b>  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL HOSPITAL</b>  |      |   |  |   | d. STREET ADDRESS<br><b>6 WEST DEER PARK DRIVE</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>BABY</b> Middle <b>GIRL</b> Last <b>STEVENS</b>  |      |   |  |   | <b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>28</b> Year <b>19 67</b>  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>5. SEX</b><br><b>FEMALE</b>  |      | <b>6. COLOR OR RACE</b><br><b>WHITE</b> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>DEC. 28, 1967</b> |  | <b>9. AGE</b> (In years last birthday) <b>NB</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td><b>10</b></td> <td><b>-</b></td> </tr> </table> |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. |  |  | <b>10</b> | <b>-</b> |
| IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.                        |  |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| Months  | Days | Hours                                   | Min.   |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
|   |      | <b>10</b>                               | <b>-</b>   |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>NEWBORN</b>  |      |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>MONTGOMERY-CTY, MD.</b>   |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>13. FATHER'S NAME</b><br><b>ALBERT STEVENS</b>   |      |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>BERTHA S. LINGER</b>   |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |      |   | <b>16. SOCIAL SECURITY NO.</b><br><b>NONE</b>  |   | <b>17. INFORMANT</b> Address<br><b>MEDICAL RECORDS-MONTGOMERY GEN. HOSP.</b>   |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b> 10h<br><b>7620</b> DUE TO <b>Coronary arteriosclerosis</b> 10h<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)     |      |   |  |   |  |   |  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>   |      |   |  |   |  |   |  |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |      |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |      |   | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town) (County) (State)</b>  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>12/28</b> , 19 <b>67</b> , to <b>12/28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , 19 <b>67</b> , and that death occurred at <b>11:45AM</b> , from causes and on the date stated above.  |      |   |  |   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>22a. SIGNATURE</b><br>  |      |   |  |   | <b>22b. DATE SIGNED</b><br><b>12/29/67</b>   |   | <b>22c. PHYSICIAN'S NAME (Type)</b> <b>C. H. LIGON, M.D.</b>   |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |      |   | <b>23b. DATE THEREOF</b><br><b>12-30-67</b>  |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Forest Oak</b>   |   | <b>23d. LOCATION (City or Town) (County) (State)</b><br><b>Gaithersburg, Montg. Md.</b>                                    |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |
| <b>24. FUNERAL DIRECTOR</b> <b>Ernest C. Gartner</b> ADDRESS <b>Gaithersburg, Md.</b>   |      |   |  |   | <b>25a. REC'D BY REGISTRAR</b> DATE <b>JAN 2 1968</b>  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br> |   |  |                 |  |                  |  |        |      |       |      |  |  |           |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17379

17380

|   |                                 |   |   |  |  |   |   |
|---|---------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                 |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>West Virginia</u> b. COUNTY <u>                    </u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (rural)</u>   |                                 |   | c. LENGTH OF STAY IN 1b<br><u>4 days</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dunbar</u>  |  |   | 85-3  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Naval Hospital</u>   |                                 |   |   | d. STREET ADDRESS<br><u>308 1/2 11th Street</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Van Cleve STILTNER</u>   |                                 |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>December 10 19 67</u>   |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>June 20, 1913</u>   |  | 9. AGE (In years last birthday) yrs.<br><u>54</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>U. S. Navy</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>                    </u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>                    </u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>George Stiltner</u>   |                                 |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Grace Monohan</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes 1931-1953</u>  |                                 | 16. SOCIAL SECURITY NO.<br><u>233-56-9592</u>   |   | 17. INFORMANT <u>Dunbar</u> Address <u>W. Va.</u><br><u>Mrs. Virginia Stiltner, 308 1/2 11th St.</u>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Encephalomalacia of left temporal parietal area</u><br><u>443X</u> DUE TO <u>massive</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO<br>(c) <u>                    </u> |                                 |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>                    </u>  |                                 |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>                    </u>                                 |   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>                    </u> |  | 20f. (City or town) (County) (State)<br><u>                    </u>            |   |   |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Dec. 6</u> , 19 <u>67</u> , to <u>Dec. 10</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Dec. 10</u> , 19 <u>67</u> , and that death occurred at <u>145 PM</u> , from causes and on the date stated above.   |                                 |   |   |  |  |   |   |
| 22a. SIGNATURE<br><u>Charles S. Reeves</u>  |                                 |   |   | 22b. DATE SIGNED<br><u>Dec. 11, 1967</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Charles S. Reeves, M. D.</u>                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>                    </u>  |                                 | 23b. DATE THEREOF<br><u>12-13-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Roselawn Gardens</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Princeton, W. Virginia</u> |   |   |
| 24. FUNERAL DIRECTOR <u>Falls Church</u> ADDRESS<br><u>Funeral Home, 1102 West Broad St., Falls Church</u>  |                                 |   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 14 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

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12-13-44

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17380

17381

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Maryland</u>   |  |
| c. LENGTH OF STAY IN 1b <u>22 days</u>   |  | d. STREET ADDRESS <u>1660 Lanier Place</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Irrene E. Stinemetz</u>  |  | 4. DATE OF DEATH <u>December 16, 1967</u>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 18, 1889</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auditor</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>G.A.O.</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Samuel W. Stinemetz</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Eliza Beth Morgan</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>- - -</u>  |  |
| 17. INFORMANT <u>William H. Alexander</u>  |  | Address <u>1660 Lanier Pl. N.W.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia Long Heart failure</u><br><u>4221</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>accro</u> DUE TO<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 20</u> , 19 <u>67</u> , to <u>Dec. 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15</u> , 19 <u>67</u> , and that death occurred at <u>A</u> M, from causes and on the date stated above.                                     |  |   |  |
| 22a. SIGNATURE <u>Russell C. Bufalino</u>  |  | 22b. DATE SIGNED <u>Dec. 16, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino M.D.</u>   |  | 22d. ADDRESS <u>University Blvd. W. St. Mo.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>12-19-1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>                          |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>  |  |
| ADDRESS <u>5130 Wisc. Ave. N.W. Washington, D.C.</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

1881

STATE OF DEATH

Protestant  
Silver Spring  
4140 Cross Hospital  
Stimmetts  
Maryland  
Washington, D.C.  
1881

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17381

17382

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Olney</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Gen. Hosp.</u>   |                           | d. STREET ADDRESS <u>17715 Cashell Rd.</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>PEARL MARIE STONER</u>   |                           | 4. DATE OF DEATH <u>DEC. 16, 1967</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/25/18</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   | 9. AGE (In years lost birthday) <u>49</u> yrs.   |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Calvin Dunfee</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                           | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |  |
| 17. INFORMANT <u>Twila Stoner Hirlinger</u>   |                           | Address <u>7528 Sweet Briar College Park, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to smoke inhalation during</u><br><u>916.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }<br>(b) <u>house fire</u><br>DUE TO<br>(c) _____  |                           |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Deceased asleep when house caught fire</u>               |  |
| 20c. TIME OF INJURY Month, Day, Year <u>12-30-12-16-1967</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |                           | 20f. (City or town) (County) (State) <u>Rockville Montg. Md.</u>   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u>   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>  |                           | 23b. DATE THEREOF <u>12/19/1967</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>BART LINCOLN CEMETARY</u>   |                           | 23d. LOCATION (City or town) (County) (State) <u>CILMAR MARYLAND</u>   |  |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. - SILVER SPRING, MD</u>   |                           | 25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |                           | 22. DATE SIGNED <u>DEC. 16, 1967</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                |  |                                     | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   |   |  |
|--|--------------------------------|--|-------------------------------------|--|---|---|--|
| 17382  |                                |  |                                     | 17383  |   |   |  |
| CERTIFICATE OF DEATH   |                                |  |                                     |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Mont.</b>   |                                | MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b>                      |   | b. COUNTY<br><b>Mont.</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                | c. LENGTH OF STAY IN 1b<br><b>3 Mos. 28 days</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>                                  |   | <b>15.1</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Potomac Valley Nursing Home</b>   |                                |  |                                     | d. STREET ADDRESS<br><b>4322 Leland St.</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lallie</b>  |                                | First Middle Last<br><b>A Street</b>   |                                     | 4. DATE OF DEATH<br>Month Day Year<br><b>12 27 19 67</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Cau</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-27-75</b> |  | 9. AGE (In years last birthday)<br><b>92 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Alabama</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 13. FATHER'S NAME<br><b>John Abergronbie</b>   |                                |  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Laura Martin</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                | 16. SOCIAL SECURITY NO.<br><b>220-44-1774</b>  |                                     | 17. INFORMANT<br><b>Laura Jackson</b><br><b>4322 Leland St. Bethesda, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Arterio-sclerotic cardiac vascular disease</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Acute viral upper respiratory infection</b> |                                |  |                                     |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Dec. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 26, 1967</b> , and that death occurred at <b>5:05 AM</b> , from causes and on the date stated above.  |                                |  |                                     |  |   |   |  |
| 22a. SIGNATURE<br><b>Alfred S. Norton</b>  |                                |  |                                     | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>12/27/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Alfred Norton</b>   |                                |  |                                     | 22d. ADDRESS<br><b>7710 Dwight Ave., Bethesda, Md.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                                | 23b. DATE THEREOF<br><b>12-27-67</b>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Md.</b>                              |  |
| 24. FUNERAL DIRECTOR<br><b>Robert A. Pumphrey</b>  |                                |  |                                     | 25a. REC'D BY REGISTRAR<br><b>Bethesda Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>O'Connell Judge</b>  |  |
| DATE <b>DEC 29 1967</b>  |                                |  |                                     |  |   |   |  |

17382

17382

UNITED STATES OF AMERICA



[The remainder of the page contains extremely faint, illegible text and markings, likely bleed-through from the reverse side of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |   |  |  |        |  |   |  |  |  |                                |                           |  |
|--|--|--|---|--|---|--|--|--------|--|---|--|--|--|--------------------------------|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |   |  |  |        |  |   |  |  |  |                                |                           |  |
| 17383  |  |  |   |  | 17384   |  |  |        |  |   |  |  |  |                                |                           |  |
| 1. DECEASED-NAME (Type or print) <i>Ester</i>  |  |  |   |  | First   |  |  | Middle |  | Last  |  | 2a. DATE OF DEATH <i>Dec.</i> Month <i>23</i> Day <i>1967</i> Year |  |                                | 2b. HOUR <i>5:30 PM</i> M |  |
| 3. SEX <i>Female</i>   |  |  | 4. RACE <i>WHITE</i>  |  |   | 5. DATE OF BIRTH <i>APRIL, 1864</i>  |  |        | 6. AGE (In years lost birthday) <i>103</i> YRS.  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                     |  | IF UNDER 24 HRS.<br>HOURS MIN. |                           |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Russia</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |        | 9. COUNTY OF DEATH <i>Montgomery</i> Md.   |   |  |  |  |                                |                           |  |
| 10. CITY OR TOWN OF DEATH <i>BETHESDA</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bethesda Silver Spring Nursing Home</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>H.W.</i>  |  |        | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  |                                |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>  |  |  | 13b. COUNTY <i>Washington</i>   |  |   | 13c. CITY OR TOWN <i>Washington</i>  |  |        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER <i>4501 Conn. Ave. N.W.</i>                 |  |                                |                           |  |
| 14. FATHER'S NAME First <i>A</i> Middle <i>BRAHAM H.</i> Last <i>GOLDEN</i>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last <i>UNKNOWN</i> |  |  |        |  |   |  |  |  |                                |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |   |  | 16b. SOCIAL SECURITY NO.  |  |  |        |  | 17. INFORMANT <i>PHILIP SURES</i> Address <i>4740 CONN. AVE. N.W.</i> |  |  |  |                                |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Broncho-Pneumonia</i><br><i>491X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |   |  |  |        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>48 hr.</i>         |  |  |  |                                |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>Arterio Sclerosis</i>   |  |  |   |  |   |  |  |        |  |   |  |  |  |                                |                           |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |        | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |  |  |                                |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |        |  |   |  |  |  |                                |                           |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |        |  |   |  |  |  |                                |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> , 19 <i>67</i> , to <i>12/23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/23</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |   |  |   |  |  |        |  |   |  |  |  |                                |                           |  |
| 22b. SIGNATURE <i>Samuel Dessoff</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |   | 22c. DATE SIGNED <i>12/23/67</i>   |  |        |  |   |  |  |  |                                |                           |  |
| 22d. PHYSICIAN'S NAME (Type) <i>SAMUEL DESSOFF</i>   |  |  |   |  |   | 22e. ADDRESS <i>1302-18th N.W. WASH. D.C.</i>  |  |        |  |   |  |  |  |                                |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE <i>12/26/67</i>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY <i>King David Mem. Garden</i>   |  |        | 23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>                       |   |  |  |  |                                |                           |  |
| 24. FUNERAL DIRECTOR <i>B. DANZANSKY &amp; SONS</i> ADDRESS <i>3501 14th St. N.W.</i>  |  |  |   |  |   | 25a. REC'D BY REGISTRAR <i>DEC 28 1967</i>   |  |        | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>  |   |  |  |  |                                |                           |  |

MEDICAL CERTIFICATION

11384

CERTIFICATE OF DEATH

11383

APRIL 1964

WITTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |
|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |
| 17384   |  | 17385   |  |
| CERTIFICATE OF DEATH  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>PL. GLEO</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>North Forestville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Colonial Villa Nursing Home</u>  |  | e. STREET ADDRESS<br><u>3418 83rd Ave.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>James E. Tapscott</u>   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>17</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-16-1944</u>   |
| 9. AGE (In years lost birthday)<br><u>73</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>D.C. Transit Operator</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bus Driver</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Clark County, Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>James E. Tapscott</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Henrietta Stickles</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u>   |  | 16. SOCIAL SECURITY NO.<br><u>578-10-6718</u>   |  |
| 17. INFORMANT<br><u>Mary B. Tapscott</u>  |  | 18. ADDRESS<br><u>3418 83rd Avenue N. Forestville, Maryland</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO (b) <u>Chronic bronchitis</u><br>DUE TO (c) <u>Emphysema</u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Cerebral arteriosclerosis</u>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (the hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>17 Dec.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>67</u> , and that death occurred at <u>6P</u> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>William Harvey</u> M.D.  |  | 22b. DATE SIGNED<br><u>17 Dec '67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>William Harvey</u>   |  | 22d. ADDRESS<br><u>2121 Penn. Ave NW</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>Dec. 20-1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Clark &amp; Wilson</u><br><u>Warner E. Pumphrey, Inc.</u>  |  | 25a. RECORD BY REGISTRAR<br><u>DEC 26 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  | 25c. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

17384

17384

RECEIVED IN DEATH

*[Faint, mostly illegible handwritten text, possibly a letter or document, with some words like "Dear" and "Yours" visible.]*

*[Faint vertical text on the right margin, possibly a date or reference.]*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17385

17386

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                               |  |                                |   |   |  |   |
|---|-------------------------------|--|--------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               |  |                                | c. LENGTH OF STAY IN 1b <u>15-1</u>   |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Suburban Hospital</u>  |                               |  |                                | d. STREET ADDRESS <u>10201 Grosvenor Place</u>  |   |  |   |
| 3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>Taylor</u>  |                               |  |                                | 4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1967</u>  |   |  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-6-01</u> | 9. AGE (In years lost birthday) <u>66</u> yrs.  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> |  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-Organist</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |                                | 11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>William T. Matthews</u>  |                               |  |                                | 14. MOTHER'S MAIDEN NAME <u>ETHEL Copplestone</u>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>578-62-5429</u>   |                                | 17. INFORMANT <u>Rev. W. Donald Taylor - son</u> Address <u>  </u>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>194X METASTATIC CARCINOMA</u><br>DUE TO (b) <u>CARCINOMA OF THYROID</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u> |                               |  |                                |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u><br><u>3 YEARS</u>                             |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>  |                               |  |                                |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |                                |   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>   |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |   | 20f. (City or town) (County) (State) <u>  </u>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>66</u> , to <u>DEC</u> , 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>DEC 26</u> , 19 <u>67</u> , and that death occurred at <u>1:30AM</u> , from causes and on the date stated above.                                    |                               |  |                                |   |   |  |   |
| 22a. SIGNATURE <u>Michaeloff</u>  |                               |  |                                | 22b. DATE SIGNED <u>12/27/67</u>  |   | 22c. PHYSICIAN'S NAME (Type) <u>MADLOFF, MICHAELS</u>  |   |
| 22d. ADDRESS <u>504 Elderwood Rd</u>  |                               |  |                                | 22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |  |   |
| 23a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)   |                               | 23b. DATE THEREOF <u>12/29/67</u>  |                                | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>  |   | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>                           |   |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>  |                               |  |                                | 25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |

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Howeville-Granville

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Washington D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma PARK</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Clinton</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>1 day 1 1/2 hr</u>   |  | d. STREET ADDRESS<br><u>7458 SAN JUAN DR.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>WASH. SAN + Hosp.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Joseph</u> Middle <u>Upton B</u> Last <u>Thompson</u>   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>10</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-17-37</u>   |
| 9. AGE (In years last birthday)<br><u>30</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ENGINEER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Philco Ford Corp.</u>   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>MARYLAND</u>                 |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>Upton Thompson</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>MIRIAM DEURY</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>yes. US Navy '64</u>                          |  |
| 16. SOCIAL SECURITY NO.<br><u>219-34-9257</u>  |  | 17. INFORMANT<br><u>Hosp Records</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>2001</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>LYMPHOSARCOMA</u><br>DUE TO<br>(c) <u>pan cytopenia</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><u>Leady Sadaghiian</u> M.D.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED   |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS<br><u>11200 LOCKWOOD BL SILVERSPRING MD</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>Dec. 13, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ST. JOHNS CHURCH CEMETERY</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>HOLLYWOOD, ST. MARY'S, MD.</u>     |
| 24. FUNERAL DIRECTOR<br><u>W. CLARKE MATTINGLEY</u>  |  | ADDRESS<br><u>LEONARDTOWN, MARYLAND</u>   | 25a. REC'D BY REGISTRAR<br><u>DEC 15 1967</u>  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>  |  |

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WESTERN BUREAU

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DEC 13 1961 ST. JOHN'S CHURCH STREET, HOLLYWOOD, FLA. 33411

CLARENCE MATTHEW LEEBARTON, MARYLAND

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

17387

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Md. Medical Examiner - 12/16/67 HFE

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WEST HAVEN</b>   |                                  | c. LENGTH OF STAY IN TB   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WEST HAVEN</b> 15.1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5310 WRILEY RD. (D.C. 20016)</b>   |                                  |   | d. STREET ADDRESS<br><b>5310 WRILEY RD.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>ANNA LARDNER TOBIN</b>   |                                  |   | 4. DATE OF DEATH Month Day Year<br><b>DEC. 7 1967</b>  |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/19/1883</b>   |  | 9. AGE (In years lost birthday) yrs.<br><b>84</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>NILES MICHIGAN</b>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |   | 13. FATHER'S NAME<br><b>HENRY LARDNER</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>LENA B. PHILLIPS</b>   |                                  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                     |  |   |
| 16. SOCIAL SECURITY NO.<br><b>081-01-6807</b>   |                                  | 17. INFORMANT (daughter) Address<br><b>ANNE WILLCOX 5310 WRILEY RD.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br>331X DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>DUE TO (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>± 30 min.</b> |                                  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ASTHMA - ARTERIOSCLEROTIC HEART DISEASE</b>   |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>—</b>  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b>                         |   |
| 20f. (City or town)<br><b>—</b>   |                                  | 20g. (County)<br><b>—</b>   |  | 20h. (State)<br><b>—</b>   |   |
| 21. I certify that (1) (this hospital) attended the deceased from <b>FEB</b> , 19 <b>67</b> , to <b>DEC</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>AUG 2</b> 19 <b>67</b> , and that death occurred at <b>6:15 AM</b> , from causes and on the date stated above.   |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>Henry D. Ecker</b>   |                                  |   | 22b. DATE SIGNED<br><b>12/7/67</b>   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>HENRY D. ECKER MD</b>  |                                  |   | 22d. ADDRESS<br><b>916-19th St. N.W. - DC 20006</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |                                  | 23b. DATE THEREOF<br><b>12/8/1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Episcopal Church Cem. Douglaston, L.I. N.Y.</b>              |   |
| 23d. LOCATION (City or Town)<br><b>—</b>  |                                  | 23e. (County)<br><b>—</b>   |  | 23f. (State)<br><b>—</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gaudens Down</b>  |                                  | 24a. ADDRESS<br><b>5130 Washington Ave NW Wash. D.C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 15 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |                                  |   |  |  |   |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17388

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |                                    |  |   |   |  |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>—</u> b. COUNTY <u>—</u>  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><u>25 days</u>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium &amp; Hospital</u>   |                                  |   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Martha Frances Todd</u>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><u>December 15 19 67</u>   |   |   |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-1-85</u> | 9. AGE (In years lost birthday)<br><u>82</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired School Teacher</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>EDUCATION</u>   |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Illinois</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                 |  |
| 13. FATHER'S NAME<br><u>Henry Riffin</u>  |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Emily Price</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  |   |                                    | 16. SOCIAL SECURITY NO.<br><u>5 19-42-7632</u>   |   |   |  |
| 17. INFORMANT<br><u>Martha Todd-Chesterfield, Missouri</u>  |                                  |   |                                    | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) <u>Cerebro-sclerosis</u><br>DUE TO (c) <u>Rheumatoid Arthritis</u> |   |   |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><u>18 days</u>  |                                  |   |                                    | 20. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Generalized Arterio-sclerosis</u>   |                                  |   |                                    |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>—</u>   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>—</u>   |   | 20f. (City or town) (County) (State)<br><u>—</u>                            |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 19 67</u> to <u>Dec 15, 19 67</u> , that (I) (we) last saw the deceased alive on <u>Dec 14, 19 67</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above. |                                  |   |                                    |  |   |   |  |
| 22a. SIGNATURE<br><u>George L. Ball</u>   |                                  |   |                                    | 22b. DATE SIGNED<br><u>Dec 15, 1967</u>  |   | 22c. PHYSICIAN'S NAME (Type)<br><u>George L. Ball</u>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>—</u>   |                                  | 23b. DATE THEREOF<br><u>12/18/1967</u>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |   | 23d. LOCATION (City or town) (County) (State)<br><u>Rockville, Maryland</u> |  |
| 24. FUNERAL DIRECTOR<br><u>C. Glen Carter</u>   |                                  |   |                                    | 25a. REC'D BY REGISTRAR<br><u>—</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. —</u>                           |  |
| 25c. ADDRESS<br><u>Warner E. Humphrey, Inc. 8434 Ga. Avenue Md.</u>   |                                  |   |                                    | 25d. DATE<br><u>DEC 21 1967</u>  |   |   |  |

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Palmer School of Education

2001/11

From 1910

Henry Ridd.

Cerebral Thrombosis

Gerapno - 2010/02/25

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212392-0174H-5051050000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17389

17390

|  |                                  |  |                                   |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>  |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                   |
| c. LENGTH OF STAY in lb<br><u>5 weeks</u>  |                                  | d. STREET ADDRESS<br><u>12515 Georgia Ave.</u>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Holy Cross Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Jane</u> Middle <u>Francis</u> Last <u>Tophill</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>12</u> Year <u>1967</u>  |                                   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>6/4/06</u> |
| 9. AGE (In years last birthday)<br><u>61</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>   |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>District of Columbia</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                   |
| 13. FATHER'S NAME<br><u>William Bean</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Kerr</u>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>No</u>   |                                   |
| 17. INFORMANT<br><u>Lionel A. Tophill, Sr.</u>   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Saddle Embolus Due To Peritonitis</u><br><u>1533</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Multiple Peritoneal Abscesses</u><br>DUE TO<br>(c) <u>Perforated Carcinoma Of Sigmoid Colon (1 Week)</u> |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Week</u>  |                                   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>67</u> , to <u>12/12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/11</u> , 19 <u>67</u> , and that death occurred at <u>11:25 a.m.</u> from causes and on the date stated above. |                                  |  |                                   |
| 22a. SIGNATURE<br><u>Harold S. Tidler</u>  |                                  | 22b. DATE SIGNED<br><u>12/12/67</u>  |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Harold S. Tidler</u>  |                                  | 22d. ADDRESS<br><u>9402 Fenton Street, Silver Spring, Md.</u>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Dec. 15, 1967</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. John's Forest Glen</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Forest Glen, Maryland</u>  |                                   |
| 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>DEC 18 1967</u>  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                  |  |                                   |

17380

17380

STATE DEPARTMENT OF HEALTH

REPORT OF DEATH

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERVIEW

INTERVIEWER

DATE OF REPORT

REPORTER

SIGNATURE

DATE

7

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

BB

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |  |   |   |  |
|---|--|--|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |   |   |  |
| 17390   |  |  |   |   |  |  |   |   |  |
| 17391   |  |  |   |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>17 days</u>     |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda, Maryland</u>  |  |  |   |   | d. STREET ADDRESS<br><u>5134 Alberta Avenue 21236</u>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Daniel Philip Trumpe</u>   |  |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>December 22 19 67</u>   |  |   |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6 March 1924</u>                                    |   | 9. AGE (In years lost birthday) yrs.<br><u>43</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Lithographer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Cotton</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>       |   |  |
| 13. FATHER'S NAME<br><u>Raymond Trumpe</u>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Cyvilla Myers</u>   |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes 1942-1946</u>  |  |  | 16. SOCIAL SECURITY NO.<br><u>217-16-8500</u> |   | 17. INFORMANT <u>The Medical Records</u><br><u>The Clinical Center, Bethesda, Maryland</u>   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO<br>(c) <u>Endogenous Hyperlipemia</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 hours</u><br><u>5 Years</u><br><u>43 Years</u>           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>ot work ot work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |   |   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 5, 1967</u> , to <u>December 22, 1967</u> , that (I) (we) lost saw the deceased alive on <u>December 22, 1967</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.   |  |  |   |   |  |  |   |   |  |
| 22a. SIGNATURE<br><u>Ferid Murad</u>  |  |  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>23 December 1967</u>   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Ferid Murad, MD.</u>   |  |  |   |   | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12-27-1967</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National Cem.</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Co. Md.</u> |   |   |  |
| 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home</u>   |  |  |   |   | ADDRESS<br><u>740 Balair Road</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 27 1967</u> |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |

10331

STATE OF TEXAS

10331

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3

4

5

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17391

17392

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>     |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>  |  | c. LENGTH OF STAY IN 1b<br>_____  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HYATTSVILLE</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>HOLY CROSS HOSPITAL</u>  |  |   |  | d. STREET ADDRESS<br><u>8306 14th AVENUE</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>MORTON</u> Middle <u>UTERMAN</u> Last <u>UTERMAN</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>DECEMBER</u> Day <u>13</u> Year <u>1967</u>  |  |  |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>4-15-1911</u>   |  |
| 9. AGE (In years last birthday) yrs. <u>56</u>  |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SALESMAN</u>                   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AUTOMOBILE</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>NEW YORK</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  | 13. FATHER'S NAME<br><u>ISAAC UTERMAN</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>ANNA SICKLICK</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>111-09-9888</u>  |  | 17. INFORMANT<br><u>Diana Bengis</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive heart failure, acute</u><br>DUE TO<br>(c) <u>Arteriosclerotic cardio vascular disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 Min.</u><br><br><u>1 Hr.</u><br><br><u>5 Yrs.</u>  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>diabetes mellitus</u> |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work _____ of work _____<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>67</u> to <u>12/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>67</u> , and that death occurred at <u>9:10 AM</u> , from causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>Myron L. Lenken</u>  |  |   |  | 22b. DATE SIGNED<br><u>12-13-67</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br>22d. ADDRESS<br>22e. REC'D BY REGISTRAR<br>22f. REGISTRAR'S SIGNATURE<br><u>Charles J. Jones</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12-17-1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>National Memorial Park</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Falls Church Va.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Goldberg Funeral Home 4217 9th Street N. W.</u>  |  |   |  | DATE <u>DEC 20 1967</u>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11382

CERTIFICATE OF DEATH

11381

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17392

17393

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | c. LENGTH OF STAY IN 1b <u>16 days</u>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | 151   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |                               | d. STREET ADDRESS <u>8704 Irvington Ave.</u>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Ethel Mae Urwick</u>  |                               | 4. DATE OF DEATH<br>Month Day Year<br><u>December 8 19 67</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1894</u><br><u>3/5/1894</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs.   |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington - DC</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>Charles Lippett</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Genvie unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>213-48-2715</u>  |   |
| 17. INFORMANT <u>Mrs. Kelsh - Shaw</u> (daughter)  |                               | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u><br>DUE TO (c) <u>Coronary Arteriosclerosis</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>2 weeks</u><br><u>YEARS</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>67</u> , to <u>12/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> from causes and on the date stated above.  |                               |   |   |
| 22a. SIGNATURE <u>Sidney J. Malawer</u>  |                               | 22b. DATE SIGNED <u>12/8/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Sidney J. Malawer</u>  |                               | 22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>12/11/67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>  |                               | 23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, (P.G.Co) Md.</u>  |   |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons 5130 Wisconsin Av. N.W.</u>   |                               | ADDRESS <u>Wash. D.C.</u>   |   |
| 25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>   |                               | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |

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RECEIVED

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "sent" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 154  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) <b>RINZE VANDERVEEN</b>   |  | 2a. DATE OF DEATH <b>Dec</b> Month <b>28</b> Day <b>1967</b> Year   |  | 2b. HOUR <b>5:35</b> P.M.   |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b>   | 5. DATE OF BIRTH <b>May 29-1915</b>   |  | 6. AGE (In years lost birthday) <b>52</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <b>Holland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <b>Montgomery</b> Md.   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>22 No Summit</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>IBM</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>  | 13b. COUNTY <b>MONTGOMERY</b>  | 13c. CITY OR TOWN <b>Gaithersburg</b>   | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13e. STREET AND NUMBER <b>22 No. Summit</b>   |  |
| 14. FATHER'S NAME First <b>Rinze A.</b> Middle <b>VanderVeen</b> Lost  | 15. MOTHER'S MAIDEN NAME First <b>Martha K.</b> Middle <b>Elhome</b> Lost                        |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> (If yes give year or dates of service) <b>W2</b>   | 16b. SOCIAL SECURITY NO. <b>113-07-0959</b>  | 17. INFORMANT <b>Margaretha W. VanderVeen</b> Address <b>Gaithersburg 22N Summit Av</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4201</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO SCLEROSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b><br><b>YEARS</b> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>NONE</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Summer 1967</b> , to <b>Dec 28, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Dec 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE <b>STEVEN CONWAY MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED <b>Dec 28 1967</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>STEVEN CONWAY MD</b>   |  | 22e. ADDRESS <b>570 NO FREDERICK Gaithersburg, Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>   | 23b. DATE <b>12-30-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Bladensburg. Md.</b>                           |  |
| 24. FUNERAL DIRECTOR <b>Ernest C. Dartner</b> ADDRESS <b>Gaithersburg. Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>JA</b> DATE <b>3 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Dist/ of Col.</b> b. COUNTY<br>- - -                |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> 473   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Carroll Hall Nursing Home</b>  |                                  | d. STREET ADDRESS<br><b>4000 Massachusetts Ave. N.W.</b>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br><b>MARY</b> First Middle Last<br><b>E. VENCILL</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 21 1967</b>   |                                     |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-6-1878</b> |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - -  |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>Louis Cass Morris</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ellen Devlin</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>- - -  |                                  | 16. SOCIAL SECURITY NO.<br>- - -  |                                     |
| 17. INFORMANT<br><b>Genevieve Vencill- See Item No. 2</b>   |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident -</b><br><b>442X</b> DUE TO <b>Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Generalized Cerebrovascular disease</b><br>(c) <b>None</b> |                                  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>  |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>None 19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (1) (this hospital) attended the deceased from <b>12/13</b> , 19 <b>67</b> , to <b>present</b> , that (2) (we) last saw the deceased alive on <b>12/20</b> 19 <b>67</b> , and that death occurred at <b>11:19 AM</b> from causes and on the date stated above.   |                                  |   |                                     |
| 22a. SIGNATURE<br><b>John B. Umhan</b>  |                                  | 22b. DATE SIGNED<br><b>12/22/67</b>   |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN B. UMHAN MD</b>   |                                  | 22d. ADDRESS<br><b>8805 Conn. Ave. Chevy Chase</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 23b. DATE THEREOF<br><b>12-22-1967</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Masonic Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Silver City, N.M.</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc. %130</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>Wisc. Ave. N.W. Wash. D.C.</b>  |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  | DATE<br><b>DEC 28 1967</b>  |                                     |

17350

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17395

## CERTIFICATE OF DEATH

17396

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>1 da.</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greenbelt</u>   |                                  | 16.2   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>HOLY CROSS HOSPITAL</u>   |                                  | d. STREET ADDRESS<br><u>5910 Cherrywood Terrace</u>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ENRIQUE</u> Middle <u>MIRALLES</u> Last <u>VERA</u>  |                                  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>18</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>DEC. 17, 1967</u> |
| 9. AGE (In years last birthday)<br><u>Today</u>  |                                  | IF UNDER 1 YEAR<br>Months <u>23</u> Days <u>40</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>ENRIQUE MARTINEZ VERA</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>LILIAN MIRALLES SILVA</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>-</u>  |  |
| 17. INFORMANT<br><u>ENRIQUE VERA</u>   |                                  | Address <u>BRENBOLT, MD.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>776X Prematurity</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>776X</u><br>DUE TO<br>(c) <u>776X</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/12/15, 1967</u> to <u>6/18/18, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/18, 1967</u> , and that death occurred at <u>6:20</u> M, from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><u>MJ. Moore</u>   |                                  | 22b. DATE SIGNED<br><u>12-18-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MARVIN MOORE</u>  |                                  | 22d. ADDRESS<br><u>1003 SPRING ST</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>12/23/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cem</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Silver Spring, Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Tyson Wheeler</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>DATE DEC 29 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DOI: 10.1002/for

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17397

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  |  |  | d. STREET ADDRESS <u>3606 Dundee Dr</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>Virginia</u> Middle <u>Wagner</u> Last   |  |  |  | 4. DATE OF DEATH <u>Dec.</u> Month <u>15</u> Day <u>1967</u> Year  |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>MAY 1, 1902</u>  |  |
| 9. AGE (In years last birthday) <u>65</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min. |  | 11. IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Mineral, Virginia</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |
| 13. FATHER'S NAME <u>HENRY JOHNSON</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ANGELINA PATERSON</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT <u>Lewis H. Croce</u>   |  |  |  | Address <u>3608 Dundee Dr. Chevy Chase, Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201</u> <u>Coronary insufficiency, acute</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, severe</u><br>DUE TO<br>(c) <u>7 years</u>  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John M. Ball</u> M.D.   |  |  |  | 22. DATE SIGNED <u>12/15/67</u>  |  |  |  |
| EXAMINER'S NAME (Type)  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>12/18/67</u>          |  | 23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, P.G. Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>JOSEPH GAWLER &amp; SONS 5130 Wisconsin Ave</u>   |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |  |  |

17328

Corporation, Secretary, Secretary  
Corporation, Secretary, Secretary

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form SM-3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

17395

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17398

|   |                               |  |  |   |   |
|---|-------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery.</u>   |                               | MARYLAND--   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery.</u> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda.</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>6 Mo.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Topaz Home, 4400 East West Hwy.</u>  |                               | d. STREET ADDRESS<br><u>4400 East West Hwy.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Walter</u> First <u>(NMI)</u> Middle <u>Wallace.</u> Last   |                               | 4. DATE OF DEATH<br>Month <u>Dec-</u> Day <u>10</u> Year <u>19 67</u>  |  |   |   |
| 5. SEX<br><u>M.</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>Sept. 3, 1905</u> | 9. AGE (In years last birthday)<br><u>62</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electronics Engr</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Philippines.</u>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                               | 13. FATHER'S NAME<br><u>John. Walczykowski</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Marcela Martinis</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Yes</u> <u>WW II</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>379-40-2905</u>  |  | 17. INFORMANT <u>Wife</u> Address<br><u>Metta R. Wallace Same as Item 2.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute.</u><br>DUE TO (b) <u>Cardiovascular Disease -</u><br>DUE TO (c) <u>years.</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hr.</u>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town) (County) (State)  |                               | 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| 22. DATE SIGNED<br><u>12/10/67</u>  |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | Address (Street, city, town, or county) <u>Bethesda, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 23b. DATE THEREOF<br><u>12-13-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington Natl. Cem.</u>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Arlington, Virginia</u>   |                               | 25a. REC'D BY REGISTRAR<br><u>DEC 15 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>   |                               | ADDRESS  |  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

D.M.E. DECEASED IN FALL NOTIFIED APPROVED

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17398

## CERTIFICATE OF DEATH

17399

|   |                                  |   |                                     |   |   |   |  |
|---|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ROCKVILLE</u>  |                                  | c. LENGTH OF STAY IN 1b   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ROCKVILLE</u>  |   | 15.1  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>10401 GROSVENOR PLACE</u>  |                                  |   |                                     | d. STREET ADDRESS<br><u>10401 GROSVENOR PLACE</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>WILLIAM</u> Middle <u>WEINBERG</u> Last <u>WEINBERG</u>   |                                  |   |                                     | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>18</u> Year <u>1967</u>  |   |   |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>4-7-1907</u> |   | 9. AGE (In years last birthday)<br><u>60</u> yrs. | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SELF-EMPLOYED</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>ART DEALER</u>  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><u>NEW YORK</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>ISIDORE WEINBERG</u>  |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>ANNA REISANFEL</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>   |                                     | 17. INFORMANT<br>Address <u>MRS BEN WEINBERG SAME AS 21</u>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial Infarct</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u><br>DUE TO (c) |                                  |   |                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |                                     |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>48</u> , to <u>Dec 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-7-</u> 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from causes and on the date stated above.                   |                                  |   |                                     |   |   |   |  |
| 22a. SIGNATURE<br><u>Herbert Abramson</u> M.D.  |                                  |   |                                     | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |   | 22b. DATE SIGNED<br><u>12-18-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>HERBERT ABRAMSON, M.D.</u>   |                                  |   |                                     | 22d. ADDRESS<br><u>1250 - Conn Ave NW Wash DC</u>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 23b. DATE THEREOF<br><u>1-22-1967</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>NEW MONTFLORE CEM.</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>PINELAWN, L.I. N.Y.</u>                       |  |
| 24. FUNERAL DIRECTOR<br><u>GOLDBERG FUNERAL HOME 4217 9TH ST. N.W.</u>  |                                  |   |                                     | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 20 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>  |  |

17338

CERTIFICATE OF DEATH

17338

Post Mortem Report

67

48 1848  
1848

4-26

67

12-7-67

12-18-67

HERBERT ABRAMSON M.D. 1810 - Comm Gen Hlt. Wash. DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| 17399  |                               | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                                   | 17400   |   |
|--|-------------------------------|--|-----------------------------------|---|---|
| 1  |                               | CERTIFICATE OF DEATH   |                                   |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>   |                                   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>   |                               | c. LENGTH OF STAY IN 1b <u>10-28-67</u>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON, VIRGINIA</u> <u>83.3</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>  |                               | d. STREET ADDRESS <u>231 N George Mason Dr</u>   |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>BERTHA</u> Middle <u>T.</u> Last <u>Whaley</u>   |                               | 4. DATE OF DEATH <u>Dec. 14</u> 19 <u>67</u>   |                                   |   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>1-25-1909</u> | 9. AGE (In years last birthday) <u>58</u> yrs.  | IF UNDER 1 YEAR Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON DC</u>  |   |
| 13. FATHER'S NAME <u>CHARLES KAISER</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>CLARA ANN DEITRICH</u>   |                                   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>557-03-7747</u>   |                                   | 17. INFORMANT <u>MARGARET M PEULTON</u> Address <u>Kensington Md. 10225 Kens. Pkway</u>                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cachecia</u><br><u>199.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO<br>(c) <u>Primary Pleuric</u> |                               |  |                                   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town) (County) (State)   |                               | 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 7</u> , 19 <u>67</u> to <u>12/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>67</u> , and that death occurred at <u>3:50</u> P.M. from causes and on the date stated above. |                                   |   |   |
| 22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.   |                               | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                                   | 22b. DATE SIGNED <u>12/14/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>  |                               | 22d. ADDRESS <u>ROCKVILLE, MD. 20852</u>   |                                   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 23b. DATE THEREOF <u>12-16-67</u>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK FALLS CHURCH, VA.</u>                                      |   |
| 24. FUNERAL DIRECTOR <u>F.J. COLLINS</u> ADDRESS <u>3821-14th ST. N.W. D.C.</u>  |                               | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |                                   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |
| DATE <u>DEC 18 1967</u>  |                               |  |                                   |   |   |

1740

UNITED STATES OF AMERICA

1788

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "AMERICA" are visible.]*

UNITED STATES OF AMERICA

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>FLORENCE HENDERSON WHEELER</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>Dec</b> Day <b>24</b> Year <b>1967</b> |   |  | 2b. HOUR<br><b>10:15 PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH<br><b>1-31-1878</b>  |  | 6. AGE (In years last birthday)<br><b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>INDIANA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>WHEATON</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>UNIVERSITY NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOME MAKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>BETHESDA</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Unknown</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>309-09-0301</b>  |  | 17. INFORMANT Address<br><b>NURSING RECORDS</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4211</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aortic Insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19____, to <b>12-24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Dec 24</b> , 19 <b>67</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Kramer M.D.</b>   |  | 22c. DATE SIGNED<br><b>12/24/67</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>ROBERT KRAMER</b>  |  | 22e. ADDRESS<br><b>8484 16th ST. S.S. Md.</b>  |  |
| 23a. DATE OF CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>12/28/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pt Geo To Md.</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>W. K. Huntemann &amp; Son, Funeral Home</b>  |  | 24b. ADDRESS<br><b>5732 Georgia Ave N.W.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**特約記者**

1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17401

17402

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>c. LENGTH OF STAY in lb<br><b>17 months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Oak Haven Nursing Home</b>  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Prince George</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chillum</b><br>d. STREET ADDRESS<br><b>625 Sheridan Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>GERTRUDE Cora</b><br>First Middle Last<br><b>WHELAN</b>   |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>DEC 29 1967</b>  |   |  |
| <b>5. SEX</b><br><b>F</b>  |  |  | <b>6. COLOR OR RACE</b><br><b>wh.</b>  |   |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  | <b>8. DATE OF BIRTH</b><br><b>April 26, 1983</b>   |   |  |
| <b>9. AGE</b> (In years last birthday)<br><b>84</b> yrs.   |  |  | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.   |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Retired House Cleaner</b>   |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>District Govt.</b>  |   |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Georgetown, DC</b>  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Unknown</b>   |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b>  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>217-52-8293</b>   |   |  |
| <b>17. INFORMANT</b><br><b>Wallace F. Whelan-12717-Rigdale Ter. S. S. Md.</b>  |  |  | <b>Address</b>   |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b><br>DUE TO<br>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Cerebral Arterio-sclerotic syndrome</b><br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>St. showed progressive deterioration and died of Terminal Pneumonia</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>on wake</b> |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour e.m. p.m. <b>19</b>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  |
| <b>20f. (City or town)</b>   |  | <b>(County)</b>  |  | <b>(State)</b>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from July 9, 1966 to 12/29, 1967, that (I) (we) last saw the deceased alive on 12/27, 1967, and that death occurred at 6 P.M. from the causes and on the date stated above.</b>  |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><b>R. S. Williams</b><br>M.D.   |  |  |  |   |  |
| <b>22b. DATE SIGNED</b>  |  |  |  |   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>R. S. WILLIAMS</b>   |  |  |  |   |  |
| <b>22d. ADDRESS</b><br><b>35 NEW YORK AVE. NW.</b>   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |  | <b>23b. DATE THEREOF</b><br><b>Jan 3, 1968</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Olivet</b>                |  |
| <b>23d. LOCATION</b> (City, town or county)<br><b>Washington, DC</b>   |  | <b>(State)</b>   |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>C. Glen Carter</b><br><b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>   |  |  |  |   |  |
| <b>25a. REC'D BY REGISTRAR</b><br><b>JAN 9 1968</b>  |  |  |  |   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Jones</b>  |  |  |  |   |  |

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v. 10, p. 1590

1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 25

Warner E. Rembert, Inc., Detroit, Mich.

638 E. J. Dale

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17402

17403

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b><br>c. LENGTH OF STAY IN TB<br><b>1 yr. 5 mos.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>University Nursing Home</b>                   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>d. STREET ADDRESS<br><b>4977 Battery Lane, Apt. XXXX</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Helen H. White</b>   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>16</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>11-27-1895</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  | 9. AGE (In years lost birthday)<br><b>72</b> yrs.                               |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Brooklyn, New York</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>John Hanson</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lizzie Swenson</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>578-12-5580A</b>   |   |
| 17. INFORMANT<br><b>Husband</b>   |  | Address<br><b>Lincoln White</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL BRONCHOPNEUMONIA</b><br>DUE TO (b) <b>CEREBRAL ATROPHY</b><br>DUE TO (c) <b>MASSIVE C.V.A.'s</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>1 1/2 yrs</b><br><b>1 1/2 yrs.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>CONTRIBUTING TO DEATH</b>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour: o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>NOV 20, 1949</b> to <b>DEC 16, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Dec 11, 1967</b> , and that death occurred at <b>7:23 AM</b> , from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><b>Robert G. Angle</b>  |  | 22b. DATE SIGNED<br><b>DEC 16, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ROBERT G. ANGLE</b>  |  | 22d. ADDRESS<br><b>5009 Del Ray Ave. Bethesda, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12-18-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Silver Spring, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 21 1967</b>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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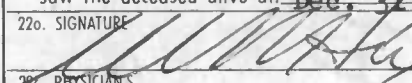
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25M 1/67

17403

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17404

|  |                                 |   |   |  |   |   |                                |
|--|---------------------------------|---|---|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |                                 |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>✓</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b>  |                                 | c. LENGTH OF STAY IN 1b<br><b>29 days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annandale</b> 83-3                            |   |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Naval Hospital</b>  |                                 |   |   | d. STREET ADDRESS<br><b>4509 Old Columbia Pike</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Lloyd Franklin WHITE</b>  |                                 |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 31 19 67</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cauc</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 2, 1906</b> |  | 9. AGE (In years last birthday)<br><b>61</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Johnson County, N.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                |
| 13. FATHER'S NAME<br><b>Thomas L. White</b>  |                                 |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Guthridge</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1927 to 1957</b>  |                                 | 16. SOCIAL SECURITY NO.<br><b>224-52-3231</b>   |   | 17. INFORMANT<br><b>Annandale, Va.<br/>Mrs. Eleanor White 4509 Old Columbia Pike</b>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Suppurative Peritonitis</b><br><b>576X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                 |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2</b> , 19 <b>67</b> , to <b>Dec. 31</b> , 19 <b>67</b> , that <del>I</del> (we) last saw the deceased alive on <b>Dec. 31</b> , 19 <b>67</b> , and that death occurred at <b>1155A</b> , from causes and on the date stated above.  |                                 |   |   |  |   |   |                                |
| 22a. SIGNATURE<br>  |                                 |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>31 DEC 67</b>  |                                |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W.R. Hix, M.D.</b>  |                                 | 22d. ADDRESS<br><b>Naval Hospital, Bethesda, Maryland</b>   |   |  |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 23b. DATE THEREOF   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Va.</b>                            |                                |
| 24. FUNERAL DIRECTOR<br><b>Everly-Wheatley</b>   |                                 |   |   | 25a. REC'D BY REGISTRAR<br><b>1500 West Broad Rock Road Alexandria, Virginia</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                       |                                |
|  |                                 |   |   | DATE<br><b>JAN 8 1968</b>  |   |   |                                |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17404

17405

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Washington</b> b. COUNTY <b>D. C.</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 months</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Potomac Valley Nursing Home</b>  |                                  | d. STREET ADDRESS<br><b>4301 Warren St., N. W.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Agnes</b> Middle <b>Virgina</b> Last <b>Williams</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>30</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct 18 1886</b>                                     |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  |
| 12. BIRTHPLACE (County & State, or foreign country)<br><b>Fredericksburg Va.</b>  |                                  | 13. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 14. FATHER'S NAME<br><b>Sanford Allen</b>   |                                  | 15. MOTHER'S MAIDEN NAME<br><b>Sarah Henderson</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 17. SOCIAL SECURITY NO.<br><b>223 66 8344</b>   |  |
| 18. INFORMANT<br><b>Mrs Bertha Henderson</b>  |                                  | Address <b>4301 Warren St Washington, DC</b>  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4500</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CONGESTIVE HEART FAILURE</b> DUE TO<br>(c) <b>ARTERIO SCLEROTIC HEART FAILURE</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2+ days</b><br><b>WEEKS</b><br><b>YEARS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>GEN'L ARTERIO SCLEROSIS UREMIA</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>D. N. A.</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/9</b> , 19 <b>67</b> , to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>12/29</b> 19 <b>67</b> , and that death occurred at <b>3 A</b> M, from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Charles Savarese, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>12/30/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>CHARLES SAVARESE, M.D.</b>   |                                  | 22d. ADDRESS<br><b>11125 ROCKVILLE PK, ROCKVILLE MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt View Baptist</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>King George Cty Md</b> |
| 24. FUNERAL DIRECTOR<br><b>Robert A Pumphrey</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>7557 Wisconsin Ave Bethesda, Md</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |                                  | DATE <b>JAN 5 1968</b>  |  |

VR A15 (4)  
25M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17405

CERTIFICATE OF DEATH

17406

|  |                                  |   |                                      |  |   |   |  |
|--|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u><br>c. LENGTH OF STAY IN 1b <u>2 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>       |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Washington, D. C.</u> b. COUNTY <u>47-3</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u><br>d. STREET ADDRESS <u>5922 13th St., NW</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Leslie Franklin Williams</u>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><u>12/9 19 67</u>  |   |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/26/1894</u> | 9. AGE (In years last birthday)<br><u>73 yrs.</u>  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Warehouseman</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>D.C. School Dist.</u>   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Phila., Pa.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                |  |
| 13. FATHER'S NAME<br><u>William Williams</u>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Ida Liza Lecture</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes WW I</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>197-09-4332</u>   |                                      | 17. INFORMANT<br><u>Gertrude Williams</u> Address <u>5922 - 13th Street, N.W. Washington, D. C.</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u><br>DUE TO (b) <u>onset two years -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 years</u> |                                  |   |                                      |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                      |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-7</u> , 19 <u>67</u> , to <u>12-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.                             |                                  |   |                                      |  |   |   |  |
| 22a. SIGNATURE<br><u>Myron L. Lenkin</u>   |                                  |   |                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><u>12-9-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Myron L. Lenkin</u>   |                                  |   |                                      | 22d. ADDRESS<br><u>2309 Shorefield Rd, Wheaton, Md.</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Dec. 13, 1967</u>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D. C.</u> |  |
| 24. FUNERAL DIRECTOR<br><u>C. Glen Carter</u>  |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br><u>DEC 13 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                          |  |
| 26. FUNERAL HOME<br><u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>   |                                  |   |                                      |  |   |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17407

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cabin John</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cabin John</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>25 Carver Rd.</u>  |  |   |  | d. STREET ADDRESS<br><u>25 Carver</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Virginia</u> Middle <u>E.</u> Last <u>Williams</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>19</u> Year <u>1967</u>   |  |  |  |
| 5. SEX <u>Fe.</u>   |  | 6. COLOR OR RACE <u>Colored</u>           |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><u>Sept. 16, 1916</u>  |  |
| 9. AGE (In years last birthday)<br><u>51</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Charwoman</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>G.S.A.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Montvale, Virginia</u>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Allen Curtis</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary A. Carter</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address <u>25 Carver Rd., Cabin John, Md.</u><br><u>Mr. Charles E. Williams</u> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>465X</u> IMMEDIATE CAUSE (a) <u>Pulmonary infarction, bilateral</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                           |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>John E. Ball</u><br>EXAMINER'S NAME (Type)   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><u>12/20/67</u> |  |  |  |
| 22. DATE SIGNED   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12/23/67</u>      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Montvale, Va.</u>  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br><u>McGuire Fun. Serv. Inc., 1020 North St., N.W. DC</u>   |  |   |  | ADDRESS<br><u>Wash., D.C.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 27 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |   |  |  |  |

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(1)

Charles Jones

VR A15 (4)  
15M 9/60

cleared with medical examiner

11201

Montgomery

Silver Spring

2000 Gayer Avenue

Cambridge

Montreal

St. Louis

11-1-1917

Washington, D.C.

Central Avenue

St. Paul

2000 Gayer Avenue

Silver Spring

Montgomery

11201

JAN 2 1917

U.S. DEPARTMENT OF AGRICULTURE

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>✓</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>   |  |
| c. LENGTH OF STAY in 1b <u>1 mo.</u>   |   | d. STREET ADDRESS <u>7904-16th ST. N.W.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MERLE</u> Middle <u>K.</u> Last <u>WOOD</u>  |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>25</u> Year <u>1967</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 30, 1898</u>         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Federal employee</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <u>69</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Horace H. Wood</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Nellie Kuhn</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |   | 16. SOCIAL SECURITY NO. <u>579-60-1466</u>  |  |
| 17. INFORMANT <u>Ruth R. Wood same as #2</u>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Circumstances of pneumonia</u><br><u>157X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO<br>(c) _____ |   | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)           |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/23, 1967</u> , to <u>12/25, 1967</u> that (I) (we) last saw the deceased alive on <u>12/24, 1967</u> and that death occurred at <u>6 A.M.</u> from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE <u>[Signature]</u>  |   | 22b. DATE SIGNED <u>12/25/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>B.H. Kreuzburg</u>   |   | 22d. ADDRESS <u>7852 16th Ave NW DC</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>   |   | 23b. DATE THEREOF <u>12/28/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State) <u>Toledo, Ohio</u>   |  |
| 24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u>   |   | 25a. REC'D BY REGISTRAR <u>[Signature]</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |   | DATE <u>DEC 27 1967</u>   |  |

13407

UNITED STATES OF AMERICA

1909

District of Columbia

Washington, D.C.

1001-1012 St. N.W.

December 2, 1909

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267-3rd St. S.E.

1909

New York

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17409

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|   |                              |   |                                    |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>Mary Kensington</b><br>b. COUNTY <b>Montgomery</b><br>Maryland  |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                              | c. LENGTH OF STAY IN TB<br><b>DOA</b>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Silver Spring</b><br><b>Holy Cross Hospital</b>  |                              | d. STREET ADDRESS<br><b>3912 Wabington St.</b><br><b>S</b>  |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Martin</b> <sup>First</sup> <b>Herbert</b> <sup>Middle</sup> <b>Wright</b> <sup>Last</sup>   |                              | 4. DATE OF DEATH<br><b>Month 12 Day 24 Year 67</b><br>19  |                                    |
| 5. SEX<br><b>m</b>  | 6. COLOR OR RACE<br><b>w</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3 31 00</b> |
| 9. AGE (In years last birthday)<br><b>67</b> yrs.   |                              | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                    |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>electrician</b>  |                              | 12. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, DC</b>  |                              | 12. CITIZEN OF WHAT COUNTRY<br><b>US</b>  |                                    |
| 13. FATHER'S NAME<br><b>Herbert Wright</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Elva Manning</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW1</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>218 05 6066</b>   |                                    |
| 17. INFORMANT<br><b>Ethel W. Wright same item # 2-wife</b>  |                              | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO <b>Chronic degenerative disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic degenerative disease</b><br>DUE TO <b>Chronic degenerative disease</b><br>(c) <b>Chronic degenerative disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b> |                              |   |                                    |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>  |                              |   |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1948</b> , to <b>12-24, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 1967</b> , and that death occurred at <b>1230 PM</b> , from causes and on the date stated above.  |                              |   |                                    |
| 22a. SIGNATURE<br><b>J.S. Rogers</b><br>22c. PHYSICIAN'S NAME (Type)  |                              | 22b. DATE SIGNED<br><b>12-24-67</b><br>22d. ADDRESS<br><b>Seminary Rd., Silver Spring, Md.</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>12/28/67</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Rockville, Md.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Wilson Wheeler Funeral Home-133 Rockville Pike</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b><br>DATE <b>12-24-67</b>   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Ordered by Dr. Rep. - 12-24-67 / bawman 99

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |  |
| c. LENGTH OF STAY IN 1b <u>16 mos.</u>  |  | d. STREET ADDRESS <u>11931 Viers Mill Road</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11931 Viers Mill Road</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>James Robert Zehner</u>  |  | 4. DATE OF DEATH <u>Dec. 18 1967</u>   |  |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/27/19</u>   |
| 9. AGE (In years lost birthday) <u>47</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hi-Fi Equipment</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Anderson, Indiana</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Gloyd Zehner</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Irene Sandifer Shaffer</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II - Korea</u>   |  | 16. SOCIAL SECURITY NO. <u>Yes</u>   |  |
| 17. INFORMANT <u>Margaret Zehner</u>  |  | 18. ADDRESS <u>11931 Viers Mill Road Wheaton, Maryland</u>   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>  |  |  |  |
| DUE TO (b) <u>ARTERIOsclerotic HEART Disease</u>  |  |  |  |
| DUE TO (c) <u>2 years</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm; factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>Dec 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 17 1967</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <u>Raymond T. Benack MD</u>  |  | 22b. DATE SIGNED <u>12/18/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>  |  | 22d. ADDRESS <u>4115 Colie Dr. Wheaton, Md.</u>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Dec. 20, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Warner Clark &amp; Son, Inc.</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>   |  | 25c. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>   |  |

STATEMENT OF DEATH

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|                         |  |                               |  |
|-------------------------|--|-------------------------------|--|
| 1. Name of deceased     |  | 2. Date of death              |  |
| 3. Place of death       |  | 4. Cause of death             |  |
| 5. Name of informant    |  | 6. Signature of informant     |  |
| 7. Name of physician    |  | 8. Signature of physician     |  |
| 9. Name of funeral home |  | 10. Signature of funeral home |  |
| 11. Name of next of kin |  | 12. Signature of next of kin  |  |
| 13. Name of coroner     |  | 14. Signature of coroner      |  |
| 15. Name of registrar   |  | 16. Signature of registrar    |  |
| 17. Name of undertaker  |  | 18. Signature of undertaker   |  |
| 19. Name of cemetery    |  | 20. Signature of cemetery     |  |
| 21. Name of church      |  | 22. Signature of church       |  |
| 23. Name of school      |  | 24. Signature of school       |  |
| 25. Name of employer    |  | 26. Signature of employer     |  |
| 27. Name of neighbor    |  | 28. Signature of neighbor     |  |
| 29. Name of friend      |  | 30. Signature of friend       |  |
| 31. Name of witness     |  | 32. Signature of witness      |  |
| 33. Name of witness     |  | 34. Signature of witness      |  |
| 35. Name of witness     |  | 36. Signature of witness      |  |
| 37. Name of witness     |  | 38. Signature of witness      |  |
| 39. Name of witness     |  | 40. Signature of witness      |  |
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| 43. Name of witness     |  | 44. Signature of witness      |  |
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| 89. Name of witness     |  | 90. Signature of witness      |  |
| 91. Name of witness     |  | 92. Signature of witness      |  |
| 93. Name of witness     |  | 94. Signature of witness      |  |
| 95. Name of witness     |  | 96. Signature of witness      |  |
| 97. Name of witness     |  | 98. Signature of witness      |  |
| 99. Name of witness     |  | 100. Signature of witness     |  |

Special Agent in Charge, Federal Bureau of Investigation  
Washington, D. C. 20535  
Date: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Title: \_\_\_\_\_